BANGKOK HOSPITAL PATTAYA

Consent Form for Release of Patient Medical Information

I, Mr. / Mrs. /Miss _____ H.N._____ Date of birth_____

Age: _____ National ID card/ Driving license/ other card is _____ Number: _____

Home address: _____ Street: _____

District: _____City: _____ Country: _____ Phone No.: _____

☐ I agree and consent for the hospital to disclose medical information to insurance companies or other parties responsible for my medical expenses as per details below.

☐ Request my medical documents from my hospitalization in Bangkok Hospital Pattaya from date _____ to _____ as per details below (Tick relevant boxes)

- ☐ Copy of all medical records which are out-patient records, in-patient records, check-up results etc.
- ☐ All investigation results ○ Laboratory results ○ Report of X-rays (Imaging data)
- ☐ Information or history of HIV treatment
- ☐ Information or history of psychiatric treatment
- ☐ Information or treatment history of sexually transmitted disease
- ☐ Consent to notify the test result by phone
- ☐ Information or treatment history about alcohol and substance abuse
- ☐ Claim form
- ☐ Information or history of Genetic Testing
- ☐ Post -mortem/ Autopsy certificate
- ☐ Doctor's certificate to claim government or State Enterprise benefits
- ☐ Consent to disclose personal information including ID card, passport, driving license, insurance card, travel document etc.
- ☐ Other _____

Remark: _____

_____

Documentation Request(s) for the following reasons:

- ☐ For a claim from insurance company
- ☐ For a compensation claim from Social Security
- ☐ For a compensation claim from government and state enterprise office
- ☐ For pre-employment check-up
- ☐ For continuing medical treatment at (name of hospital) _____
- ☐ For insurance application
- ☐ For a medical profile to be kept at my current company
- ☐ Other (please specify) _____

In which this patient information has been request by:

- ☐ Self
- ☐ Self over the telephone consent
  - ○ Consent ○ Not consent
  - Signature of staff who request a consent_____ Date_____ Time_____
- ☐ Authorize/ Legal Guardian _____ _____
  Name Relationship

National ID Card/ Passport No : _____

Address: _____ Telephone: _____

I acknowledge and understand that all medical patient information is confidential and secured by the Bangkok Hospital Pattaya and will only be released to an authorized person. Information that is collected by someone other than a BPH employee could be re-disclosed and is no longer under protection from the hospital. This consent form authorizes others to proceed on my behalf.

Signature: _____Patient/Legal Guardian/Authorized person/ Health check-up recipient

(_____)
(Printed Name)

Signature: _____ Witness

(_____)
(Printed Name)

Documents to be collected by:

- ☐ Self/ Legal Guardian/ Authorized Person

Signature: _____Patient/Legal guardian/Authorized person/Health check-up recipient

(_____)

Date _____ Time _____

- ☐ Mail to address: _____Tracking No._____Sender_____Date_____
- ☐ Fax/ Fax No. _____ Sender_____Date_____Time_____
- ☐ Email address: _____Sender_____Date_____Time_____

Note: The patient's authority means the rightful representative of a minor (not over 20 years old or under the age of majority by registered marriage). The Legal Guardian of the incompetent by court order, legal guardian of the person who is incapacitated by court order.

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For hospital use only

Part 1: Document enclosed with the application

The applicant	Documents
○ Patient	☐ Consent form ☐ ID card copy
○ The legal guardian	☐ Consent form ☐ Court orders ☐ ID card copy of patient ☐ Death certificate ☐ ID card copy of the legal guardian ☐ Birth certificate ☐ Copy of Home Registration Book (In case of the patient doesn't reach the legal age or the parent's name are registered in Home Registration Book)
○ The authorized person	☐ Consent Form ☐ ID card copy of patient ☐ ID card copy of the legal guardian ☐ Service fee _____ baht (for insurance company) ○ Cash ○ Cheque from Bank _____ No. _____

Part 2: If requesting medical information

From _____Department

Doctor / Assignee_____

○ Patient

○ The legal guardian/ The authorized person Mr. / Mrs. / Miss. _____

Wishes to receive the requested medical information as per page 1 starting from:

Date _____ to _____

Your approval is requested,

Name _____ (Registration Staff)

(_____)

Date _____ Time _____

Acknowledged and proceed as _____

_____

_____

Physician / Assignee

Date _____ Time _____