PUSAT PERUBATAN
PRINCE COURT
MEDICAL CENTRE

For enquiry, please call
+603-2160 0000 ext 1707 / 1709 or
email to medicalreport@princecourt.com

Note: Minimum processing period is 30 working days.

Date Request: ……

Date Complete: ……

Date Informed: ……

APPLICATION FOR RELEASE OF MEDICAL INFORMATION

Ref. No. :

PATIENT'S INFORMATION

Name of patient : _____ Date of Birth: _____

NRIC/Passport No.: _____ MRN/Encounter: _____
(Please provide copy of NRIC/Passport)

Attending Doctor : _____ Specialty: _____

REQUESTOR'S INFORMATION

Name : _____

Contact No. : _____ NRIC/Passport No.: _____
(Please provide copy of NRIC/Passport)

Email : _____

Relationship to patient: ☐ Self ☐ Next-of kin (please specify): _____
☐ Insurance Agent ☐ Others (please specify): _____

REPORT TYPE

☐ Medical Report (Free Text) ☐ Claim Form _____
(please state name of insurance company / agency)

☐ Laboratory Results ☐ Radiology Results ☐ Discharge Summary

☐ Vaccination Records ☐ KWSP/EPF ☐ PERKESO/SOCSO

☐ Others (please specify): _____

COLLECTION OF REPORT

☐ On-site collection at Medical Report Unit, Level 1B, Prince Court Medical Centre

☐ Postal/Courier Services (please provide postal address): _____

_____

☐ Email: _____

***Important Note for the Requestor:**

1. If requestor is a third party personnel, the Consent for Release of Medical Information signed by the patient must be submitted together with this application form.
2. A copy of requestor's NRIC/Passport and patient's NRIC/Passport are required for verification purposes.
3. There shall be an administrative fee of RM20 and a **minimum** doctor's fee of RM100.
4. If you are sending a representative to collect the report on your behalf, an authorization letter signed by patient is required.

By signing the below, I hereby confirm that the information provided above are accurate, correct and complete and that the documents submitted along with this application form are genuine.

Requestor's Name: _____ Signature: _____ Date : _____

FOR OFFICE USE ONLY

DOCTOR'S AUTHORIZATION

☐ Approved for release **REPORT FEES: RM** _____

☐ Not approved for release)

(Justification: _____)

Doctor's Signature:

Prepared by HID staff:

Name: _____

Date: _____

Released by HID staff:

Name: _____

Date: _____

Report delivered: ☐ Email ☐ Post Date: _____

COLLECTION OF REPORT:

Authorization Letter:

☐ Yes ☐ Not applicable

Collected by (name):

_____

Signature:

_____

NRIC/Passport No.:

_____

Date: Time:

_____ _____