



PUSAT PERUBATAN
PRINCE COURT
MEDICAL CENTRE

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

Date Request:

Date Complete:

Date Informed:

**Note: Processing period is
14 working days.**

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.: _____

Email : _____ (Please provide copy of NRIC/Passport)

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 4B, 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.
5. Any request of medical information for a deceased patient, a **Grant of Probate** or **Letter of Administration** is compulsory.
6. Only applications with completed documentations will be processed.

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		<u>COLLECTION OF REPORT:</u>	
<u>DOCTOR'S AUTHORIZATION</u>		Authorization Letter:	
<input type="checkbox"/> Approved for release	REPORT FEES: RM _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Not approved for release)		Collected by (name): _____	
(Justification: _____)		Signature: _____	
Doctor's Signature: _____		NRIC/Passport No.: _____	
Prepared by HID staff:	Released by HID staff:	Date: _____	Time: _____
Name: _____	Name: _____	_____	
Date: _____	Date: _____	_____	
Report delivered: <input type="checkbox"/> Email <input type="checkbox"/> Post		Date: _____	