Hospital unit no :

_____

Patient's name :

_____

CONSENT TO THE RELEASE OF INFORMATION

Requested by

Name _____**(signature)**

Passport/Alien registration no._____

Phone(or mobile) no._____

Address _____

Relationship to the patient		Necessary documentation
□ Patient	→	□ Passport/Alien registration card
□ Other_____	→	□ Passport/Alien registration card
		□ Patient authorization form

* Authorization by the patient is needed to release a medical record copy to an individual other than the patient for the protection of the patient's personal information.

Reason for request

□ Treatment at another hospital
□ Submission to an insurance company
□ Submission to the military manpower administration
□ Personal copy
□ Submission to another organization_____

_____

□ Other_____

Continuing to the next page

Copied dental treatment record

□ The whole dental treatment record of an authorized clinic
□ Outpatient treatment & progress record
□ Pathology report
□ Clinical laboratory examination report
□ Radiology report
□ Other examination report
□ Emergency record
□ Inpatient record
□ Operation record
□ Other record_____

I certify that the above authorized person is qualified and agree to release a copy of medical record indicated above.

201 . .

Dept/clinic _____

Charge dentist _____**(signature)**