Jerudong Park Medical Centre

Organization Accredited Joint Commission International

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the following protected health information to be released from the medical record of:

Patient's Name _____ PRN _____

Address with Post Code _____

Contact Numbers _____ E-mail Address _____

INFORMATION / RECORDS RELEASED

☐ Medical Report ☐ Discharge Summary ☐ Investigation Reports ☐ Claim Form ☐ Insurance Form

☐ Photocopies of Medical Records ☐ Other(s), Please Specify: _____

_____

_____

_____

NOTE: If specific dates to be released or a specific provider are not indicated, all records in the category furnished will be released.

Release Records	Jerudong Park Medical Centre	Release Records
☐ From ☐ To	Jerudong Park, BG 3122 Brunei Darussalam **T** (673) 261 1433 ext 2139, 2216 **F** (673) 261 2461 **E** emr.info@jpmc.com.bn	☐ To ☐ From

_____ (Name / Organization)

_____ (Address with Post Code)

_____ (Phone Number) _____ (Fax Number) _____ (Mobile Number)

☐ Please **MAIL** the documents ☐ Please **CALL** when the documents are ready for pick-up ☐ Please **FAX** the documents

I understand that the information may no longer be protected once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

REASON FOR RELEASE OF INFORMATION:

_____

I understand that this authorization is valid for six months unless I notify Jerudong Park Medical Centre (JPMC) otherwise. I may revoke this authorization in writing at any time except to the extent that JPMC has already relied on this authorization. I may revoke it by mailing or faxing a written notice to the Medical Records Department, JPMC, stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. I will be billed per the posted fee schedule. The information will be provided to me within 21 days of my request.

NOTE: If mailing or faxing this form, Please include a copy of your photo ID.

_____ **Signature of patient**

_____ **Signature of the Authorized Representative**

Date _____

Relationship with patient _____