

## RELEASE OF MEDICAL INFORMATION REQUEST/AUTHORISATION FORM

| Please specify    I understand that I may revoke this authorisation at any time by written notification to Mediclinic Al Mussafah following this date, except for the information which may have been released prior to the revocation. This consent form will be effective for one year from date of signature.    Signature  | (Patient Name)                                 |                      | _MRN  | Date of Birth                               |
|--|--|----------------------|---|---|
| Contact no. Address The release of medical information shall be done via:    Mail   In person   Email  | Contact no                                     | authorise Mediclinio | c Al Mussafah to rele   | ase information to                          |
| The release of medical information shall be done via:    Mail   In person   Email  | (Name of person or organisation if differ      | rent from above name | d patient)  |   |
| Mail   In person   Email   | Contact no Ad                                  | ddress               |   |   |
| *Reports will only be released in English. Please ensure completion of all fields. Submission of incomplete forms will result in a delay of issuance of medical information.  Date of visit to Mediclinic Al Mussafah  Doctor's name  Type of information to be released (please check all that apply)  Laboratory reports  Please specify  Regular medical report (Maximum three working days)  (You will be charged Dhs 100/- for written medical report)  Please specify  Please specify  Comprehensive medical report (Maximum five working days)  (You will be charged Dhs 100/- for written medical report)  Please specify  Please specify  Comprehensive medical report (Maximum five working days)  (You will be charged Dhs 430/- for written medical report)  Please specify  I understand that I may revoke this authorisation at any time by written notification to Mediclinic Al Mussafah following this date, except for the information which may have been released prior to the revocation. This consent form will be effective for one year from date of signature.  Signature  Patient or person giving consent (name printed)  The signature is of the  Patient Parent of minor Legal guardian Patient's next of kin  Person authorised by patient | The release of medical information s           | shall be done via:   |   |   |
| Date of visit to Mediclinic AI Mussafah    Doctor's name   | ☐ Mail ☐ In person ☐ Email                     |                      |   | Other                                       |
| Type of information to be released (please check all that apply)  Laboratory reports  Please specify   | ,  | ,                    | etion of all fields. Subm   | ission of incomplete forms will result in a |
| Laboratory reports   | Date of visit to Mediclinic Al Mussafah        |                      | Doctor's name   |   |
| Laboratory reports   |  |                      |   |   |
| Please specify   | Type of information to be released             | (please check all th | at apply)   |   |
| Radiology reports (x-ray, ultra sound, CT, MRI reports)  Please specify  Other  Please specify  Please specify  Comprehensive medical report (Maximum five working de (You will be charged Dhs 430/- for written medical report)  Please specify  I understand that I may revoke this authorisation at any time by written notification to Mediclinic Al Mussafah following this date, except for the information which may have been released prior to the revocation. This consent form will be effective for one year from date of signature.  Signature  Patient or person giving consent (name printed)  The signature is of the  Patient Parent of minor Legal guardian Patient's next of kin  Person authorised by patient  | Laboratory reports                             |                      | ☐ Discharge summary (Maximum three working days)  |   |
| Radiology reports (x-ray, ultra sound, CT, MRI reports)   Please specify   | Please specify                                 |                      | _ regard: medical report ( raximam me werking days)   |   |
| Other  Please specify  | $\square$ Radiology reports (x-ray, ultra sour | nd, CT, MRI reports) | (You Will be charg  | gea Dns 100/ - for written medical report)  |
| Please specify   | Please specify                                 |                      | Please specify  |   |
| I understand that I may revoke this authorisation at any time by written notification to Mediclinic Al Mussafah following this date, except for the information which may have been released prior to the revocation. This consent form will be effective for one year from date of signature.    Signature  | Other  |                      |   |   |
| I understand that I may revoke this authorisation at any time by written notification to Mediclinic Al Mussafah following this date, except for the information which may have been released prior to the revocation. This consent form will be effective for one year from date of signature.    Signature  | Please specify                                 |                      | Comprehensive medical report (Maximum five working da<br>(You will be charged Dhs 430/- for written medical report) |   |
| following this date, except for the information which may have been released prior to the revocation. This consent form will be effective for one year from date of signature.  Signature Patient or person giving consent (name printed)  The signature is of the Patient Parent of minor Legal guardian Patient's next of kin  Person authorised by patient  |  |                      | Please specify  |   |
| Patient or person giving consent (name printed)  The signature is of the  Patient Parent of minor Legal guardian Patient's next of kin  Person authorised by patient   | following this date, except for the in         | formation which ma   | ay have been release  |   |
| The signature is of the  Patient Parent of minor Legal guardian Patient's next of kin  Person authorised by patient  |  | printed)             | Date  |   |
| Patient Parent of minor Legal guardian Patient's next of kin  Person authorised by patient   |  |                      |   |   |
|  | ☐ Patient ☐ Parent of minor ☐                  |                      |   | f kin                                       |
|  |  |                      |   |   |

Mediclinic Al Mussafah has no obligation/responsibility for the reports given to the authorised person

• Complete and sign the form then hand it over in main reception or e-mail to: MCME-Musaffah@mediclinic.ae