

# RELEASE OF MEDICAL INFORMATION REQUEST/ AUTHORISATION FORM

I (Patient Name) \_\_\_\_\_ MRN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Contact no. \_\_\_\_\_ authorise Mediclinic Al Jowhara Hospital to release information to

\_\_\_\_\_  
(Name of person or organisation if different from above named patient)

Contact no. \_\_\_\_\_ Address \_\_\_\_\_

The release of medical information shall be done via:

Mail  In person  Email \_\_\_\_\_  Fax \_\_\_\_\_  Other \_\_\_\_\_

*\*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 Jowhara Hospital**

**Doctor's name**

_____	_____
_____	_____
_____	_____

**Type of information to be released (please check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Laboratory reports</b><br>Please specify _____<br><br><input type="checkbox"/> <b>Radiology reports</b> (x-ray, ultra sound, CT, MRI reports)<br>Please specify _____<br><br><input type="checkbox"/> <b>Other</b><br>Please specify _____<br>_____ | <input type="checkbox"/> <b>Discharge summary</b> (Maximum three working days)<br><input type="checkbox"/> <b>Regular medical report</b> (Maximum five working days)<br>(You will be charged Dhs 100/- for written medical report)<br>Please specify _____<br>_____<br><input type="checkbox"/> <b>Comprehensive medical report</b> (Maximum five working days)<br>(You will be charged Dhs 430/- for written medical report)<br>Please specify _____<br>_____ |
|---|--|

I understand that I may revoke this authorisation at any time by written notification to Mediclinic Al Jowhara Hospital 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** \_\_\_\_\_ **Date** \_\_\_\_\_  
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** \_\_\_\_\_  
**Relationship to patient, if any** \_\_\_\_\_

- Complete and sign the form then hand it over in main reception or e-mail to: [AAN7-MedicalRecords@mediclinic.ae](mailto:AAN7-MedicalRecords@mediclinic.ae)
- Medical record department staff will call and inform you once the report is ready and if any delay in process
- For further clarification - contact the Medical Records Department, T +971 3 705 1514 or e-mail to: [AAN7-MedicalRecords@mediclinic.ae](mailto:AAN7-MedicalRecords@mediclinic.ae)

**Mediclinic Al Jowhara Hospital has no obligation/responsibility for the reports given to the authorised person**