

RELEASE OF MEDICAL INFORMATION REQUEST/ AUTHORISATION FORM

I (Patient Name) _____ MRN _____ Date of Birth _____

Contact no. _____ authorise Mediclinic Deira 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 Deira

Doctor's name

_____	_____
_____	_____
_____	_____

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

Laboratory reports

Please specify _____

Radiology reports (x-ray, ultra sound, CT, MRI reports)

Please specify _____

Other

Please specify _____

Discharge summary (Maximum three working days)

Regular medical report (Maximum five working days)
(You will be charged Dhs 100/- for written medical report)

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 Deira 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)

Date

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

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