โรงพยาบาลทีอาร์พีเอช
TRPH
61/39 Kokkhan Road, Thap Thiang, Muang,
Trang 92000 Tel;075 218 988 Fax; 075 214684

FM-TRP-015 Rev. 00 01 / 07/ 2021

CONSENT FORM FOR RELEASE OF PATIENT MEDICAL INFORMATION

I'm Mr. / Mrs. /Miss _____ H.N. _____ Date of birth _____

Age: _____ National ID card / Driving license / other card is _____Number _____

Home address _____ Street:_____District: _____ City:_____
Country: _____ Phone No.: _____

A certificate of the hospitalization in TRPH Hospital from date _____ to_____ is requested

Request: ❒ Medical treatment history – diagnosis, hospitalization and laboratory result
❒ Post -mortem /Autopsy certificate ❒ Medical check-up report ❒ Claim form
❒ All films and report of X-rays and_____❒ Other_____
❒ Doctor's certificate to claim government or State Enterprise benefits

Remark: _____

Request for patient information is by:
❒ Self
❒ Authorize/ Legal Guardian _____ _____
Name Relationship
National ID Card /Passport No_____
Address: _____
Telephone: _____

I acknowledge and understand that all medical patient information is confidential and secured by the TRPH Hospital and will only be released to an authorized person. Information that is collected by someone other than a TRPH Hospital employee may be re-disclosed and is no longer protected by the hospital. This consent form authorizes others to proceed on my behalf.

Signature: _____ Patient/Legal Guardian Authorized Person
(_____)

Signature: _____ Authorized Person
(_____)

Documentation Request(s) for the following reasons:
❒ For a claim from insurance company ❒ For continuing medical treatment at (name of hospital)
❒ For a compensation claim from Social Security ❒ For insurance application
❒ For a compensation claim from government and state enterprise office ❒ For a medical profile to be kept at my current company
❒ For pre-employment check-up ❒ Other (please specify)_____

Documents to be collected by:
❒ Self/ Legal Guardian/Authorized Person
❒ Mail to address: _____
❒ Fax/ Fax No. _____
❒ Email, only medical check-up results may be sent by email: _____
Note: Faxed information will not contain HIV results, drug abuse or mental health treatment

I have received the patient medical information that I requested.

Signature: _____
(_____)
Date _____
❒ Patient ❒ Legal Guardian ❒ Authorized Person

Note: Someone charged with the authority of the patient means the rightful representative of a patient less than 18 years old unless they have a marriage certificate. The Legal Guardian has been assigned by court order.

Name ……Date of Birth……..Room……..Age……
HN ……EN/AN……Visit Date……Religion……Gender……
Physician……Allergies ……

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For hospital use only

Part 1: Document enclosed with the application

The applicant	Documents
Patient	Requesting application ID card copy
The legal guardian	❒ Requesting application ❒ Court orders ❒ ID card copy of patient ❒ Death certificate ❒ ID card copy of the legal guardian ❒ Birth certificate ❒ Copy of Home Registration Book (In case of the patient doesn't reach the legal age or the parent's name are registered in Home Registration Book)
The authorized person	❒ Consent Form ❒ ID card copy of patient ❒ ID card copy of the legal guardian ❒ Service fee_____ baht (for insurance company) ○ Cash ○ Cheque from Bank _____ Number _____

Part 2: With requests for medical information

For staff's department

Doctor / _____

○ Patient

○ The legal guardian / The authorized person Mr. / Mrs. / Miss. _____

Wishes to receive the requested medical information as per page 1

starting from: Date_____ to _____

Your approval is requested,

Name _____ (Registration Staff)

(_____)

Date _____

○ Not Accept ○ Accept and should proceed as _____

_____

_____

Physician / Designee

Date _____

Name ……Date of Birth……..Room……..Age……

HN ……EN/AN……Visit Date……Religion……Gender……..……

Physician……Allergies ……