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

POWER OF ATTORNEY AUTHORIZATION TO DISCLOSE/RELEASE MEDICAL RECORDS

TRPH Hospital
61/39 Kokkhan Road, Thap Thiang,
Muang, Trang 92000. THAILAND.

Date……

I, the owner of the history, Patient name…….... Age.....year
ID Card / Passport No……Address.....

agree to authorize Mr / Mrs / Ms ……(Recipient authorize) Age.....year

ID Card / Passport No……Address.....
as a requester for a medical record on behalf of me to use for…… ……

I understand the release of my health information / medical record will no longer preserve the confidentiality of my records and the information contained therein. I hereby authorize TRPH Hospital to disclose and release medical information concerning the medical assistance provided to me by TRPH Hospital to the recipient authorize.

any action of the attorney If an accident or disgrace to me concerning my medical records that have been requested, I may not make civil or criminal claims against TRPH Hospital. I therefore signed my name in the presence of witnesses.

Signature……Patient Signature…… Recipient authorize

(……) (……)

Signature……witness Signature……witness

(……) (……)

Relationship with the patient …… position……

Note 1) Attach a copy of the ID card / passport of the authorized person. and the attorney with signature certifying true copy

2) In case of the patient is a child (0-18 years old), the father or mother is the authorized person.

3) Disclosing patient secrets to others is an offense under criminal law.

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