

APPLICATION & CONSENT FOR RELEASE OF MEDICAL INFORMATION

Name:
MRN:
Date:
IC No. / ID:
Age / Sex:
Bed / Ward:
Affix Patient's label here. If no label, fill up accordingly.

DATE :		ATTENDING DOCTOR :		
SECTION A: TYPE OF REPORT OR APPLICATION (Please tick accordingly)				
Insurance Form / SOCSO / I	EPF Medical Report	t Medical Report for Lawyer Medic	al Report for Police / KKM	
Laboratory Report	Imaging Repor	rt Others:		
SECTION B: REQUESTOR'S DETAIL				
RELATIONSHIP TO PATIENT (Please tick accordingly):				
Self (Skip the rest of this sectontinue to Patient's Particul		n Insurance Agent Othe	ers:	
Requestor's Name:		NRIC/Passport No.:		
Contact Number:		Email Address :		
Organization (if applicable) e.g., Law Firm:				
(Requestor's Signature, Date)				
SECTION C: PATIENT'S DETAILS				
Name:		MRN: Se	ex: Male / Female	
Out-patient Date: to to				
Contact Number: Email Address:				
SECTION D: DELIVERY METHOD				
Self-Collect Courier (Peninsular Malaysia: RM10, East Malaysia: RM20) Address:				
SECTION E: DETAILS OF PAYMENT				
METHOD OF PAYMENT:				
Payment made at KGSC (RM)	:	Online Banking (RM): Bank	:	
SECTION F: CONSENT OF RELEASE				
I hereby declare and confirm that I made this request freely, voluntarily and without coercion and that the information given above us accurate and true to the best of my knowledge and belief, and that the medical report is required for the purpose stated above. I understand that I may be liable for prosecution for making false declaration. Further, I undertake full liability, responsibility, duty to indemnify and release KENSINGTON GREEN SPECIALIST CENTRE ("KGSC") for any cost, legal proceeding, liability loss or damage incurred or suffered by anyone arising out or in connection with the release of the medical report shall subject to approval of KENSINGTON GREEN SPECIALIST CENTRE ("KGSC"), and I hereby authorize				
The state of the s				
(Signature or Thumb) (Signature, Name, Date)				
Form No.: F-MRD-10	Rev No.: R2	Effective Date: 23.05.2024	Page 1 of 1	