THE MIND FACULTY
Psychiatry & Psychology Medical Center

CONSENT FOR RELEASE OF MEDICAL INFORMATION

1. This form must be fully completed and signed by the PATIENT / GUARDIAN. If the PATIENT is below 18years old the form should be signed by the PATIENT'S PARENT OR GUARDIAN.
2. PATIENT has to enclose a photocopy of his / her own NRIC / Passport (front & back view), if submitting via whatapps or email.
3. The completed form must be submitted with payment of the fee either by cash, credit card or bank transfer.
4. The release of the medial information is subject to official approval.
5. Kindly note that THE MIND FACULTY SDN BHD is under an obligation to give full and frank disclosure of all material fact relating to your medical condition, including but not limited to, the Human immunodeficiency virus (HIV) and any other infectious diseases required to be notified to the Ministry of Health, the Health Sciences Authority and any other relevant authorities.

PATIENT PARTICULARS

Given Name (As in *NRIC/Passport): _____

NRIC / Passport No.:_____

Corresponding Address:_____

_____

Postcode : State :
Country :

Phone No: (o)_____(hp)_____

Email: (o)_____(private)_____

Date of Attendance:_____

REQUEST

I,_____, NRIC / Passport No._____

hereby authorize THE MIND FACULTY SDN BHD to furnish and release below stated.

TO: Name of Company or Person:_____

Address of Company or Person: _____

_____

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Type of Request:

☐	Psychiatric Report	☐	Blood Tests
☐	Scans	☐	X-rays/ECG/EEG
☐	Therapy/Counselling Report	☐	Others (Please specify)
☐	Psychological Assessment and/or Report		

Remarks:_____

Besides the above Psychiatrist / Psychology report fee, I undertake to pay any additional charges such as EEC, ECG, CBC and other laboratory charges that may be incurred in the preparation of the report. I am also aware that there will be a cancellation charge of 1/2 (50%) of the medical report fee should I decide to cancel this request.

PREFERRED MODE OF COLLECTION

☐ I will personally collect the report once it is ready.

☐ Send to my mailing address as stated above. (Courier charges is applicable according to the country of destination).

☐ The report will be collected by my representative. I am aware that an authorization letter with the representative's name & NRIC / Passport No and a copy of my NRIC / Passport have to be furnished upon collection.

I hereby declare and confirm that I have been given adequate explanation on the contents of this form, which has been fully explained to me and I have fully' understood the same. The Information given above is accurate and true to the best of my knowledge, and that the requisite information is required for the same purpose stated above. I understand that I may be liable for prosecution for making a false declaration. Further, ł confirm that I shall not hold The Mind Faculty Sdn Bhd or any of its employees, servants or agents responsible in anyway whatsoever for the release of the said medical information to any party by me in the event of any loss or damage arising directly or indirectly. as a result of or in connection with the release of such confidential information by reason of the aforesaid, I undertake full responsibility and liability arising from the release of such requisite information.

PATIENT SIGNATURE NAME :	**GUARDIAN SIGNATURE** NAME :