UKM SPECIALIST CENTRE
PUSAT PAKAR
"A Subsidiary of UKM Holdings"

CONSULTANT NAME

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

Instructions:

1. This form must be filled out correctly and signed by the patient. If the patient is under 18 years old, a signature from the parent/guardian is required.
2. Completed forms must be submitted for review by the Records Unit of UKM Specialist Centre Sdn. Bhd.
3. The UKM Specialist Centre Records Unit reserves the right to reject incomplete applications.
4. The release of medical information depends on official consent from the patient or next-of-kin.
5. The preparation period for the medical report is 14 of working days*.
6. Payment for the medical report can be made after the report is completed.

1. APPLICANT INFORMATION

Name : _____ ID/Passport No._____

Mailing Address : _____

_____

Relationship to the Patient: ☐ Myself ☐ My dependent/client (state relationship): _____

Phone No.: (Mobile) _____ (Office): _____ Email Address: _____

2. PATIENT / DECEASED INFORMATION

Name : _____ ID/Passport No._____

MRN : _____ Age : _____ Jantina : ☐ Male ☐ Female

Ward / Clinic : ☐ Sutera ☐ Baldu ☐ Songket ☐ Kristal ☐ Specialist Clinic

Date of Treatment in Clinic / Hospital Admission Date : _____

Hospital Discharge Date / Date of Death : _____

3. TYPES OF REPORTS REQUESTED

1.	General Medical Report	
2.	Insurance Medical Report (Questionnaire)	
3.	EPF (KWSP) Medical Report	
4.	SOCSO Medical Report	
5.	Comprehensive Legal Report	
6.	Other Report (please specify)	

FOR USE BY Name and address of the company or individual: _____

4. SUBMISSION METHOD

☐ Collect personally ☐ Post to the applicant's address above

5. DECLARATION

I declare that all the information I have provided is true. I permit UKM Specialist Centre Sdn. Bhd. to release the Medical Report (of myself/patient/deceased) whose details are provided above to my representative named: _____ ID/Passport No.: _____. I agree not to hold UKM Specialist Centre Sdn. Bhd. and its staff accountable for any responsibilities or legal liabilities arising from this permission.

Patient/Next-of-Kin Signature

Name : _____

Date : _____

Applicant Signature

Name : _____

Date : _____

Unit Rekod Perubatan, UKM Specialist Centre Sdn. Bhd., Tingkat 7, Blok Klinikal HCTM,
Jalan Yaacob Latif, 56000 Cheras, Kuala Lumpur
Tel: 03-23329230 I 012-9145746
unitrekodukmsc@gmail.com
Email: unitrekod.ukmsc@gmail.com
www.ukmsc.com.my

CHECKLIST FOR RELEASE OF MEDICAL INFORMATION

A. PATIENT (self)

1. Copy of patient's ID/Passport
2. Copy of treatment card
3. Relevant forms (Insurance/EPF/SOCSO/Other)
4. Other related documents
5. Payment

B. PARENT (Patient Under 18 Years Old)

1. Copy of birth certificate/MyKid/ID/Passport
2. Copy of parent/guardian ID
3. Copy of treatment card
4. Relevant forms (Insurance/EPF/SOCSO/Other)
5. Other related documents
6. Payment

C. AGENT/REPRESENTATIVE/LAWYER

1. Original consent letter from patient/next-of-kin/Embassy
2. Copy of patient's ID
3. Copy of applicant's ID
4. Copy of treatment card
5. Copy of parent/guardian ID (if applicable)
6. Copy of marriage certificate (if applicable)
7. Copy of birth certificate (if applicable)
8. Sworn statement (if applicable)
9. Copy of burial permit/death certificate (if applicable)
10. Relevant forms (Insurance/EPF/SOCSO/Other)
11. Other related documents
12. Payment

D. NEXT-OF-KIN/REPRESENTATIVE/AGENT/LAWYER (Deceased Patient)

1. Original consent letter from next-of-kin
2. Copy of next-of-kin's ID
3. Copy of applicant's ID
4. Copy of treatment card
5. Copy of marriage certificate (if applicable)
6. Copy of birth certificate (if applicable)
7. Sworn statement (if applicable)
8. Copy of burial permit/death certificate (if applicable)
9. Relevant forms (Insurance/EPF/SOCSO/Other)
10. Other related documents
11. Payment

NOTA *: EPF, SOCSO, and Insurance forms are* ***NOT*** *provided. Please obtain the forms from the respective departments/agencies.*