

Re: 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 Bangkok Hospital Pattaya 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 _____ relationship _____

National ID Card /Passport No : _____ Name _____ relationship _____

Address: _____

Telephone: _____

I acknowledge and understand that all medical patient information is confidential and secured by the Bangkok Hospital Pattaya and will only be released to an authorized person. Information that is collected by someone other than a BPH 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 Signature: _____ Authorized Person

 (Printed Name) (Printed Name)

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.

For hospital use only

Part 1: Document enclosed with the application

The applicant	Documents	
<input type="checkbox"/> Patient	<input type="radio"/> Requesting application	<input type="radio"/> ID card copy
<input type="checkbox"/> The legal guardian	<input type="radio"/> Requesting application <input type="radio"/> ID card copy of patient <input type="radio"/> ID card copy of the legal guardian <input type="radio"/> 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)	<input type="radio"/> Court orders <input type="radio"/> Death certificate <input type="radio"/> Birth certificate
<input type="checkbox"/> The authorized person	<input type="radio"/> Consent Form <input type="radio"/> ID card copy of patient <input type="radio"/> ID card copy of the legal guardian <input type="radio"/> Service fee _____ baht (for insurance company) <input type="checkbox"/> Cash <input type="checkbox"/> Cheque from Bank _____ No. _____	

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 _____