Gleneagles Hospital
PENANG

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, ____(patient's name)
IC / Passport No.________________________ hereby authorize the doctor of **Gleneagles Hospital Penang** to disclose and provide any medical information and investigation, including past medical history, with respect to my illness or injury and the treatment I received while as a patient in this hospital to

____

(state the name of the organization)

I also authorize____(full name)
IC / Passport No___________________to collect the medical report on my behalf if I am not able to collect it. A photocopy of this authorization shall be as valid as the original.

Thank you,

Yours faithfully,

Witness,

____

(Signature of patient)

Date : _____________

Name : ________________

I/C No. _______________