For Staff Use Only

☐ Copy of the petitioner's ID Card
☐ Copy of the patient's ID Card
☐ Power of Attorney
☐ Others.....

.....

MR Staff

McCORMICK HOSPITAL

Patient's Record Request Form

Place.....

Date..... Month..... Year .....

Subject Request for Patient's Records

Attention …….....

I,....., Tel……..……

Address/Place that can be contacted ……..……..

Identification Card/Legal document..... Number.....

I would like to request the following documents:

☐ Medical Report ☐ Copy of Medical Records (Please specify)……

☐ Others (Please specify)……...

Name of Patient ……..……..

Treatment Period : From (date)..... to (date).....

Purpose of Request ☐ Legal purposes ☐ Referral to ……....

☐ Health insurance application ☐ Additional document for sick leave

☐ Reimbursement from the Social Security Office / Protection for Motor Vehicle Victims Act

☐ For reference to previous medical history

☐ Additional document for claiming from Insurance (Company)……..……..…….....

In case of ☐ Accident ☐ Reclaiming Medical Fee ☐ Hospital cash benefit claim

☐ Critical illness benefit claim (Please specify the disease)……..…..

☐ Others (Please Specify)……..……

Preferred Method: ☐ Self-collection ☐ Authorized representative (Please specify name :……..)

☐ By post (within Thailand only) ☐ By Email (For continued treatment, X-ray images)

(Email : ……..……..……..)

My relationship to the patient / deceased is.....

I understand that my action may result in damages or legal consequences affecting the hospital, physicians, or staff involved in providing the requested information or processing this request. Should any damages arise from my actions, I agree to assume full responsibility and consent to this document being used as supporting evidence for any legal proceedings.

I hereby submit this request for your consideration

Yours sincerely,

(Name)..... **Petitioner**

(.....)

For Staff Use Only

……

(Medical Record Staff)

Contacted the patient / guardian to verify to verify the medical records request

.....

.....

Date..... Time.....

Acknowledgment of Receipt of Medical Report

(Name)..... **Recipient**

Date.....