MEDICLINIC
MEADOWS

RELEASE OF MEDICAL INFORMATION REQUEST/ AUTHORISATION FORM

I *(Patient Name)* _____ MRN _____ Date of Birth _____

Contact no. _____ authorise Mediclinic Meadows to release information to

_____

(Name of person or organisation if different from above named patient)

Contact no. _____ Address _____

The release of medical information shall be done via:

☐ Mail ☐ In person ☐ Email _____ ☐ Fax _____ ☐ Other _____

**Reports will only be released in English. Please ensure completion of all fields. Submission of incomplete forms will result in a delay of issuance of medical information.*

Date of visit to Mediclinic Meadows

_____

_____

_____

Doctor's name

_____

_____

_____

Type of information to be released (please check all that apply)

☐ **Laboratory reports**

Please specify _____

☐ **Radiology reports** *(x-ray, ultra sound, CT, MRI reports)*

Please specify _____

☐ **Other**

Please specify _____

_____

☐ **Discharge summary** *(Maximum three working days)*

☐ **Regular medical report** *(Maximum five working days)*
(You will be charged Dhs 100/- for written medical report)

Please specify _____

_____

☐ **Comprehensive medical report** *(Maximum five working days)*
(You will be charged Dhs 430/- for written medical report)

Please specify _____

_____

I understand that I may revoke this authorisation at any time by written notification to Mediclinic Meadows following this date, except for the information which may have been released prior to the revocation. This consent form will be effective for one year from date of signature.

Signature _____ **Date** _____

Patient or person giving consent (name printed)

The signature is of the

☐ Patient ☐ Parent of minor ☐ Legal guardian ☐ Patient's next of kin

Person authorised by patient _____

Relationship to patient, if any _____

• Complete and sign the form then hand it over in main reception or e-mail to: meadows@mediclinic.ae

Mediclinic Meadows has no obligation/responsibility for the reports given to the authorised person