SALAM

SALAM SHAH ALAM SPECIALIST HOSPITAL

CONSENT FOR MEDICAL REPORT APPLICATION

Requester : Patient ☐ Representative ☐

If Representative, tick at the Representative category. (No.2)

MRN :

1. Patient Detail

Patient Name		
NRIC / Passport No.		
Address	.....	
Contact	Phone No:	E-mail:

2. Representative Detail

Representative Category	Next of Kin ☐ ..... Agent ☐ Others ☐	
Name & NRIC/Passport	Name:	NRIC/Passport:
Contact	Phone No:	E-mail:

3. Medical Report Application Information

Admission Date:	Doctor :
Discharged Date:	

4. Medical Report Fees Schedule

No.	Types of Medical Report	Fees			
		Specialist	√	Medical Officer	√
1	Medical Report for Lawyer (Written/Type)	RM 300		RM 300	
2	Medical History / Letter Head (Written/Type)	RM 150		RM 100	
3	Insurance Form / Socso Form / EPF Form	RM 80		RM 50	
4	Reissue Immunization Record	RM 20		RM 20	
5	Reissue Immunization Book	RM 5		RM 5	
6	Photocopy of Medical Certificate	RM 10		RM 10	
7	Photocopy of Lab Report, Radiology Report & Other	RM 5		RM 5	
8	Explanatory (Clarification) Report / Correction	F.O.C		F.O.C	
9	Medical Report for Government (Police, Military, Government Dept, etc.)	F.O.C		F.O.C	
	Total (RM)				

Consent for Medical Report Release

I hereby authorize **SALAM Shah Alam Specialist Hospital** to release my medical report as requested. I acknowledge that this report contains confidential medical information and may only be disclosed for the specified purpose stated in my application.

I understand that the release of this report is subject to the hospital's policies and procedures, including applicable processing fees and the required preparation time. By signing this consent, I confirm that I have read and understood the terms of this authorization.

I further understand that the processing and release of this report will be conducted following the Personal Data Protection Act 2010 (PDPA 2010) and the hospital's privacy policy, ensuring the confidentiality and security of my personal information.

Patient/Representative Name:
NRIC/Passport :
Date:
Signature:

Recipient of Completed Medical Report

Recipient Name	
Relationship to Patient	
NRIC/Passport	
Date	
Signature	

Collection or Delivery Option

Representative Category	Self Collect ☐ Post/Courier (RM10) ☐ E-mail ☐ .....

Verification of Consent by Medical Record Staff

Staff Name	
Date	
Time	
Staff Signature	

Preparation of Patient Medical Reports (For Medical Record Use Only)

Submission Date			
Patient Name		MRN	
Date of Admission and Discharge			
Doctor In Charge			
Date of Returned Medical Report			