المستشفى الأمريكي
AMERICAN HOSPITAL
DUBAI دبي
Delivering better health in the Middle East

ص.ب. ٥٥٦٦ دبي، إ.ع.م هاتف: ٣٣٦٧٧٧٧ (٠٤) فاكس: ٣٣٦٥١٩٠ (٠٤) موقع الإنترنت:www.ahdubai.com
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Medical Records Department American Hospital Dubai
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Patient Consent for Release of Medical Information

MR Number: _____ **EN Number:** _____

Patient Name: _____ **Contact Number:** _____

Email address: _____

Date(s) of Treatment From: _____ **To:** _____

I Hereby Request Copies of the Following Medical Information:

- ☐ Complete Medical Record
- ☐ Medical Evaluation
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ History & Physical Exam
- ☐ Consultation Report
- ☐ Cardiology Reports (PFT, Stress Test, Echo)
- ☐ Medical Imaging Reports
- ☐ Pathology Reports
- ☐ Laboratory Results
- ☐ Antenatal Results 1&2
- ☐ Letter
- ☐ Medical Imaging CD (X Rays, PET Scans, CT Scans, Mammography, etc.)
- ☐ Other (Please Specify): _____

This information is to be released to: Patient

I authorize the Information to be released by: ☐ FAX ☐ EMAIL ☐ POST

This consent is valid for thirty days from the date of signature however this authorization may be revoked in writing at any time before the expiration. By signing the patient is consenting to have their medical information released and the facility its employees and physicians are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Legal Representative **Date**

Please note that your request will be processed as quickly as possible. However, please allow up to three working days for the request to be processed and your records copied.

If Applicable:	**If Applicable:**
Fax To: _____	**Mail To:** _____
Fax #: _____	**Address:** _____
Receipt Confirmed: _____	**City:** _____
Patient ID Verified: _____	**State:/Province:** _____
Date Released: _____	**Country:** _____
Released By: _____	**Postal Code:** _____