ศูนย์ศรีพัฒน์ คณะแพทยศาสตร์ มหาวิทยาลัยเชียงใหม่ Sriphat Medical Center Faculty of Medicine Chiang Mai University	Document Code FM- SMC-005-R-05(E) 24/03/2565	Department: Sriphat Medical Center Contact Number: 0-5393-6900-1
Document name: Form for request a copy of medical information		

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

Part 1 For Patient/ Legal Guardian / Authorized Person

I (Mr. / Mrs. / Miss),.....Age..... Hospital Number (HN).....

Passport ❍ National ID card ❍ Others ..... Number .....

Address in Thailand House No.....Village No..... Street.....Sub- district.....

District.....Province..... Country..... Contact No.: .....

Have given my consent to Mr. / Mrs. / Miss .....Age.....

Passport ❍ National ID card ❍ Others .....Number .....

Address in Thailand House No.....Village No..... Street.....Sub- district.....

District.....Province..... Country..... Contact No.: .....

relation with patient ❍ Self ❍Legal Guardian ❍Authorized Person ❍Insurance company.....

requested to receive medical information in the form of a hospitalization certificate from Sriphat Medical Center, Faculty of Medicine, Chiang Mai University, for the purpose of.....

In which I agree that Sriphat Medical Center/ Doctor /Medical staff who have examined and treated me. Disclosure of information concerning a disease, an injury, a medical history, consultation, prescription, or treatment. along with a copy of my medical history document who received treatment in Sriphat Medical Center, Faculty of Medicine, Chiang Mai University as follows

❍ Medical treatment history-diagnosis, hospitalization, and laboratory

❍ Claim form **(Specific Date)** ..... ❍ Other .....

Receipt of document *[Processing time is approximately 3-5 business days]*

❍ **Self-pickup**

❍ Email Address .....

❍ Other (Specify) .....

Service fee .....Thai baht ❍ Cash ❍Cheque from Bank.....No.....

I acknowledge and understand that all medical patient information is confidential and secured by Sriphat Medical Center, Faculty of Medicine, Chiang Mai University and will only be released to an authorized person. Information that is collected by someone other than Sriphat Medical Center employee may be re-disclosed and is no longer protected by the hospital.

Signature ✘..... Patient/ Legal Guardian/ Authorized Person

(.....)

Part 2 For Hospital Staff

Dear Director/ Deputy Director/ Doctor.....

Signature.....Recipient/ Creator Signature.....Head of Department

(.....) Date..... (.....) Date .....

❍ Not Accept ❍ Accept/get more information of .....

Signature..... Director/ Deputy Director/ Doctor/ Designee

(.....) Date.....