רפואה אנושית
פורצת דרך

מרכז רפואי אסף הרופא מסונף לפקולטה לרפואה ע"ש סקלר, אוניברסיטת ת"א | צריפין 70300
מחלקה רשומות ומידע רפואי
טל: 08-9779582 פקס: 08-9779964 דוא"ל: abais@asaf.health.gov.il

המרכז הרפואי שמיר

Assaf Harofeh Medical Center
Affiliated to Sackler Faculty of Medicine Tel-Aviv University | Zerifin 70300 Israel
Medical record department
Tel: +972-8-9779582 Fax: +972-8-977964 email: abais@shamir.gov.il

Waiver of medical secret

Patient's Name: _____
Surname First name

Identity Card number: | | | | | | | | | |

Information required:

☐ Discharge summary _____

☐ Ambulatory records: _____
Name of ambulatory clinic visited

☐ Emergency Room records _____
Date of visit in the Emergency department

Send to: _____ Phone number: _____
Address

I the undersigned give permission to any Doctor, Medical worker of Assaf Harofeh
Medical Center to provide information concerning my state of health to the following:

1) _____

2) _____

The purpose of this request:

_____

_____

I hereby release any Doctor, Employee or Member of staff in your Medical Center from the duty of confidentiality regarding my state of health.

I the undersigned, declare that I will not sue or have any claim for releasing my Medical records.

_____
Signature of Patient / Guardian / Representative

Name of the validator of the signature _____ Signature: _____

Validator's Identity card number: _____ Date: _____

Notes: 1) In cases where the patient is deceased, an "Order of Probate" must be
Presented to the Medical records department clerk.
If an "Order of Probate" is not available, a "Deposition of the inheritors"
And their signatures must be presented.
2) When the patient is unable to arrive to retrieve his medical records, the
patient should sign a" Letter of Authorization" allowing another individual
To retrieve the records.
The authorized individual must present to the clerk of the Medical records
Department two identity cards: The patient's Identity Card and his own,
Otherwise a "Letter of Validation" of the patients signature confirmed and
Signed by a Doctor or an Attorney should be presented.

_____
Signature & stamp

For office use only:

Case Number: _____
Department where hospitalized:_____ date of discharge _____
Medical records received / not received _____
Invoice Number: _____
Total amount received: _____

Notes: _____-_____