

Waiver of medical secret

Patient's Name: _____
Surname First name

Identity number:

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 Card

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:
