

CONSENT FOR RELEASE OF MEDICAL RECORDS

Instructions

1. This form must be fully completed and should be signed by either
 - the patient; or
 - the patient's parent (if patient is less than 16 years of age); or
 - the patient's next-of-kin (if patient is deceased, a copy of the death certificate must be produced); or
 - the patient's authorized Representative.
2. Release of medical information is subject to the provisions of the DHCC Health Data Protection Regulation, No. 7 of 2008.
3. A copy of the duly completed and signed form should be submitted to the Customer Protection Unit, Center for Healthcare Planning & Quality, Dubai Healthcare City.
4. CPQ will present the form to the DHCC Licensed Healthcare Operator/Professional.
5. The Licensed Healthcare Operator/Professional then will give a copy of the patient's complete medical records to CPQ for use during the investigation of the complaint.
6. Both CPQ and the Licensed Healthcare Operator/Healthcare Professional will keep a copy of the consent form for their records.



CONSENT FOR RELEASE OF MEDICAL RECORDS

I, _____
(Name of Patient; Parent/Spouse; Next-of-Kin; or Representative)

of _____
(Address)

hereby authorize

(Name of the DHCC Licensed Healthcare Operator / Licensed Healthcare Professional)

to furnish the Customer Protection Unit of the Center for Healthcare Planning and Quality, Dubai Healthcare City, Ibn Sina Building, Block B, PO Box 505001, with a copy of my **complete healthcare /medical records**.

I hereby declare and confirm that the information given above is accurate and true to the best of my knowledge and belief.

By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite Information.

Name of Patient / Parent/ Spouse/ Next-of-kin / Representative

Address

Signature

Date