United Family Healthcare
和睦家医疗

Beijing United Family Hospital and Clinics
北京和睦家医院及诊所
24-hour Service Center 24 小时服务热线：4008-919191
24-hour Emergency Hotline24 小时紧急热线：(010) 5927 7120

Patient Name 姓名:
Sex 性别:
Date of Birth 出生日期:
Medical Record No.病案号:

AUTHORIZATION LETTER FOR RELEASE OF INFORMATION

I am _____ (patient's name used in UFH) ID number: _____

☐ Patient self ☐ Patient's Guardian ☐ Patient's Authorized Proxy. Hereby authorize United Family Hospitals and Clinics ("UFH") to release the following information (only the portions that I have the right to review and copy as stipulated by the laws and regulations of the People's Republic of China) from the above mentioned patient's medical record from_____ to _____, with the Medical Record No: _____.

YY/ MM/ DD YY/ MM/ DD

_____

(Extent or nature of information to be released, with inclusive date of treatment. An authorization specifying "any and all information" would not be honored)

Please specify the information will be released

☐ Copy of X-ray / CT / MRI / Mammogram films
☐ Copy of Endoscopy pictures
☐ Copy of ultrasound pictures
☐ Copy of medical records
☐ Laboratory, imaging and diagnostic reports
☐ Discharge summary
☐ Discharge instruction
☐ Problem list
☐ History & physical
☐ Progress notes
☐ ER physician / nurse record
☐ Anesthesia record
☐ Consent forms
☐ Operative nursing care records
☐ Consultation reports
☐ Physician's order
☐ Nursing notes
☐ Others

By ☐Abstraction information ☐ Photocopy ☐ E-mail: _____

To _____ according to UFH policy.
(Name and address of individual or institution that is to receive the information)

I hereby release UFH from all legal liability that may arise from the release of the information requested. This authorization letter will come into effect once it is signed. This authorization letter is valid for one-time use only.

****IT IS STRONGLY SUGGESTED TO HAVE ALL MEDICAL INFORMATION, RESULTS AND APPLICATION INTERPRETED BY A QUALIFIED PHYSICIAN****

In general, UFH in this consent form, refer to any United Family Hospitals and Clinics within United Family Healthcare in China. UFH is registered in the People's Republic of China conducting its activities in accordance with Chinese Law. I agree that any controversy, claim or dispute relating to treatment in UFH will be governed and interpreted exclusively in accordance with the law of the People's Republic of China. I also agree that all controversies, claims or disputes shall be litigated, if at all, only in the Courts of the People's Republic of China, and to the exclusion of courts of any other countries.

I have the full civil capacity. Healthcare provider has explained the contents, risks and consequences of this Consent Form to me, and answered related questions.

_____ _____
Signature of Health Care Seeker Date YYYY/ MM/ DD Time: Hour: Min

If the health care seeker cannot consent for him / herself or is not competent or limited competent, the signature of either the guardian or the Authorized Proxy, must be obtained.

_____ _____
Signature Date YYYY/ MM/ DD Time: Hour: Min
(Place a copy of the authorizing and relationship documents in the medical record)

Relationship: ☐ Guardian ☐ Authorized Proxy