



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

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

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