REQUEST FOR DISCLOSURE OR REPRODUCTION OF MEDICAL RECORDS

Patient	Name	Contact Information
	Foreign Registration Number	
	Address	
Records are to Be Released to :	Name	Relationship to the Patient
	Foreign Registration Number	Contact Information
	Address	
Scope of the Records Requested & Grounds for the Request	in the Case of Disclosure (for Reading Only)	
	in the Case of Reproduction (for Photocopying)	

I, as the Patient(or a legal representative of the Patient), hereby request that any and all of my medical records and related information pertaining to my care and treatment should be released to (MENTIONED ABOVE) in such manner as stated above, in accordance with Clause 2 of Article 21 of Medical Service Act and Article 13-2 of ENFORCEMENT RULES of the same Act.

Date_____

Patient Signature_____

Note: If the Patient is under age 14, his or her legal representative shall sign this form.