AUTHORIZATION FOR DISCLOSURE OR REPRODUCTION OF MEDICAL RECORDS

Surrogate	Name	Contact Information
	Foreign Registration Number	Relationship to the Patient
	Address	
Patient	Name	Contact Information
	Foreign Registration Number	
	Address	

I, as the above described Patient, hereby appoint (MENTIONED ABOVE) as my agent to obtain medical records in such manner as stated in the REQUEST FOR DISCLOSURE OR REPRODUCTION OF MEDICAL RECORDS form, 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_____