وزارة الصحة
Ministry of Health
Saudi Health Mission
in the U.S. & Canada

Consent to Release Medical Reports
تفويض بإستلام المعلومات الطبية من المستشفى

I authorize_____ (healthcare provider) to use and disclose the protected health information described below to Saudi Health Mission to cover the period of healthcare:

a. □ from …… to …… OR

b. □ all past, present, and future periods.

-Extent of Authorization

a.□ I authorize the release of my complete health record (including records relating to mental healthcare communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)

b.□ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

-This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

-I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

-I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Patient Name: ……. Signature: …… Date…….

Personal representative Name: ……. Signature: …… Date ……

(his or her relationship to patient) ……

Hospital Name: …….....

Contact Name (at the hospital)**:** ……....

Contact Information (at the hospital)**:** …….

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