P. D. HINDUJA HOSPITAL
& MEDICAL RESEARCH CENTRE
(Established & Managed by National Health & Education Society)

11th Road, Khar (W), Mumbai - 400 052.
For Appointments: +91 22 4510 8989 / 6154 8989
For Enquiries: +91 22 6174 6000 / 4888 4000
For Emergency: +91 22 6174 6099 / 98
www.hindujahospital.com/khar

Date of Application:

AUTHORIZATION LETTER FOR RELEASE OF MEDICAL RECORDS

1. PATIENT'S PARTICULARS

Name: ____

HS No.: ____________Admission No.: ________________Doctor Name:____________________________

Admission Date: ____________Discharge Date____________________Contact: ______________________

Address:____

____

TYPES OF MEDICAL RECORDS:

- ☐ INDOOR CASE PAPER
- ☐ EMERGENCY RECORDS
- ☐ DISCHARGE SUMMARY
- ☐ CLAIM FORM TO FILL
- ☐ OPERATIVE NOTES
- ☐ OTHER (Please Specify):_____
- ☐ INVESTIGATION REPORTS
- ☐ CONSULTATION PAPERS

PURPOSE:

- ☐ INSURANCE CLAIM
- ☐ LEGAL PROCEEDINGS
- ☐ SECOND OPINION
- ☐ OTHER (Please Specify) ______________________________

Dear Sir/ Madam,
On the basis of my admission details and the Medical Record requirement mentioned above,, kindly hand over the Xerox copy of the same to my __________________________ , Name of the person________________________________as I will not be able to come to the hospital to collect it.
I agree to pay the required fees for the same and also agree to submit my self- attested photo ID proof along with the photo ID proof of the above mentioned person.

Signature of the Patient:

2. IN CASE OF PAEDIATRIC CASES / PHYSICALLY UNFIT TO SIGN / EXPIRED CASES

Dear Sir/ Madam,
The above mentioned patient is/ has_________________________ and as I am the Legal Guardian/ Responsible Person, I would require the above mentioned documents, kindly hand over the Xerox copy of the same to me/my ___________________Name of the person________________________________as I will not be able to come to the hospital to collect it.
I agree to pay the required fees for the same and also agree to submit my self- attested photo ID proof along with the photo ID proof of the above mentioned person & the patient (not in case of paediatrics cases)

Name of the Legal Guardian/ Responsible Person:
Signature of the Legal Guardian/ Responsible Person:

IMPORTANT NOTE: PLEASE TURN OVER THIS PAGE TO CHECK INSTRUCTIONS REGARDING MANDATORY DOCUMENTS TO OBTAIN PATIENT'S MEDICAL RECORDS

FOR MEDICAL RECORDS DEPARTMENT

Name: ______________________________________Date of Application:

HS No.: ____________Admission No.: _________Doctor Name:________________________________

Admission Date: ___________Discharge Date____________Contact::______________________________

Address:____

____

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- ☐ SECOND OPINION
- ☐ LEGAL PROCEEDINGS
- ☐ OTHER (Please Specify)

KINDLY NOTE

PLEASE BRING THE FOLLOWING DOCUMENTS AT THE TIME OF COLLECTING MEDICAL RECORDS WITHOUT WHICH NO PATIENT DOCUMENTS WILL BE HANDED OVER TO YOU

1) **THE DULY FILLED AUTHORIZATION LETTER FOR RELEASE OF MEDICAL RECORDS(reverse page)**
2) **PHOTO ID PROOF OF THE PATIENT**
3) **PHOTO ID PROOF OF THE PERSON COLLECTING THE DOCUMENT ON BEHALF OF THE PATIENT**

INSTRUCTIONS:

1) Charges- Consultation Paper/ Investigation reports – Rs.100/-, Indoor Case Paper Rs. 230/-, Claim Reimbursement form Rs. 400/-, Medical Certificate – Rs.290/-, Courier charges if applicable.

2) You should receive requested medical records WITHIN 72 HRS (3 WORKING DAYS) upon receipt of your payment. For any assistance contact: **mrd.khar@hindujahospital.com, MRD (022 6174 6650) Ext:6650**

3) In case you do not collect the photocopies of medical records within 60 days of request put by you, it will be discarded and fee will be doubled of standard fee for second request of same copies of medical records.

4) It is advised you keep a personal copy of any medical information you request to avoid future costs of obtaining copies.

COLLECTION TIME – 09:30 AM TO 5:00 PM ONLY (WORKING DAYS)

FOR OFFICE USE.

RECEIVED XEROX COPY OF THE ICP/ CLAIM FORM/ CERTIFICATE

Signature

Name