Authorization For Release of Health Information

Patient	Name	Phone No.
	Date of Birth (Alien Registration No.)	
	Address	
Legal Representative	Name	Relationship
	Date of Birth (Alien Registration No.)	Phone No.
	Address	
Range of medical records released and copied	Name of Medical Institution	
	Date(s) of treatment	
	Reason for Issuance	
	Type of Medical Record (written by patient)	
	Ex) Copy of medical records, prescription, operation records, examination and testing results, imaging (CD included), nursing records, copy of medical certificate, death certificate, etc.	

I (or Legal Representative) authorize the release of my medical information including copies of my medical record to the above mentioned entity ( ) in accordance to article 21 clause 2 and article 13 clause 3 of the medical law.

_____(year)/_____(month)/_____(date)

Patient(or Legal Representative)_____ (signature)