Release of Medical Information
Request/ Authorization Form

Please note: Reports will be released in English only

Patient Name: _____ RG Number: _____

Date of Birth: _____ Contact Number: _____

I authorize Prime Healthcare Group to release my medical records/information to:

Name of person/ organization _____ Relation to the patient _____

The release of medical information shall be done via:

☐ Postal Address ☐ In Person ☐ SMS ☐ Fax_____ ☐ E-mail _____

☐ Other digital communication methods like WhatsApp etc.: _____

Mail to _____ Address: _____

City _____ Postal Code _____ Country _____

Reports will only be released in English. Please ensure completion of all fields and submission of incomplete forms will result in a delay of issuance of medical records.

Date/s of visit to Prime Medical Center/ Hospital	Physician's Name

Type of information to be disclosed; (please check ✓ all that applies)

☐ Laboratory reports ☐ Medical reports

☐ Radiology reports ☐ Others (please specify): _____

Reason for request: _____

This consent is valid for thirty days from the date of signature however this authorization may be revoked in writing at any time before the expiration. By signing the patient is consenting to have their medical information released and the facility its employees and physicians are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

- Transcribed medical report by the doctor will take approximately 5 working days.
- Complete the form signed by the patient and hand it over in main reception or Scan and send it to the below email id.
- For further clarification contact MRD +97147070999 or Email: mrd@primehealth.ae

Signature of patient/ person giving consent_____ Date: _____

Name _____

Received by Prime Staff

Name/ Emp no. _____

Date _____

Received by MRD Staff

Name/ Emp. no. _____

Date _____

*The Prime Healthcare Group has no obligation/ responsibility to the reports given to the authorized person.