

Dear Sir / Madam,

Gleneagles Kota Kinabalu (GKK) is a healthcare facility, owned and managed by Pantai Medical Centre Sdn. Bhd. maintains strict confidentiality on its patients' medical records.

Access to the medical information can only be released with the written consent from the patient or next of kin or unless ordered by court.

WHO CAN REQUEST?

- Patient who is above eighteen (18) years of age ;
- If the patient is mentally or physically disable, the spouse, parent ; or
- If the patient is unmarried and below eighteen years of age, parent or legal guardian.
- Third parties with a valid written consent from the patient.
- **For deceased patients, a certified true copy of the patient's death certificate, & a Letter of Administration (where no will was made by the deceased) or Grant of Probate (where a will was made by the deceased), or 'Surat Pentadbiran Harta Pusaka', whichever applicable, as proof of legal relationship to the deceased, must be submitted with the application.**

HOW TO APPLY?

A) In Person

Please proceed to Medical Records Department
 Level 2, Block A-1, Lorong Riverson @ Sembulan, 88100 Kota Kinabalu, Sabah.

Request for reports / medical information can be made during these hours:

Monday to Friday : 8.30 a.m. - 1.00 p.m. , 2.00 p.m. - 5.00 p.m. **(Lunch hour : 1.00 p.m – 2.00 p.m)**
 Saturday : 8.30 a.m. – 12.30 p.m.
 Contact : 088 518 864, my.gkk.medicalrecords@gleneagles.com.my

B) By Mail

Complete the "Consent for Release of Medical Information" at the back of this form.
 For insurance claim, please enclose insurance claim form, complete relevant section of the form and **append your signature in the authorization section of the claim form.**
 (Note: We can only process after the patient / next-of-kin has signed the authorization section).

MEDICAL REPORT FEES

Description		(Fees Payable (RM) subject to change without prior notice at GKK discretion)
Non-Specialist / Medical Officer	Written / Typed Medical Report,	RM 50 - RM70
	Insurance Claim Form	RM 35 - RM70
Specialist	Insurance Claim Form	RM 50 - RM 150
	Medical Report	RM 100 - RM 250
	Legal Report	RM 500 - RM 2500 (depending on the required paper work for legal purpose)

Other Charges

Description		(Fees Payable (RM) subject to change without prior notice at GKK discretion)
Administrative Fee	For copies of lab results, diagnostic, imaging, discharge summaries etc.	RM 10
Courier Fee (if required)	For sending original copies to requestor by courier	RM 10 – RM 15 (Within Malaysia) Note: Courier charges outside of Malaysia will depend on the given location.

PAYMENT MODE

A. By Cash / Credit Card

B. By Cheque**, made payable to GLENEAGLES KOTA KINABALU

C. By Bank In /Online Transfer: HSBC Bank Malaysia Berhad. Account Name: **Gleneagles Kota Kinabalu**,
 Account Number: **201-816154-104** SWIFT code: **HBMBMYKLXXX** ** Note: For Personal Cheque / Bank In / Online Transfer; Please note that the completed report and receipt will only be released upon clearance of cheque / receipt of payment by Gleneagles KK's Finance Department

Explained By : _____ (staff name) Explanation Given To : _____ (specify name)



A. Personal Data Protection (PDP) Policy

By providing the information set out in this form, I consent to Gleneagles Hospital Kota Kinabalu and their representatives and/or agents collecting, using and disclosing my personal data to provide me for administrative work and other reasonably related purposes. Such purposes are set out in the IHH MY Personal Data Protection Notice, accessible at <https://gleneagles.com.my/legal/pdpnotice> or available on request.

I further confirm that all personal data I have provided is all true, up-to-date and accurate. Should there be any changes to any of my personal data, I shall notify Gleneagles Hospital Kota Kinabalu immediately. I understand that I may withdraw such consent at any time via forms available on request from our staff OR by email to Data Protection Officer at my.ihh.dpo@ihhhealthcare.com

B. Conditions / Instructions

1. This form must be fully completed and signed by the patient. If the patient is below 18 years of age, the form should be signed by the patient's parent or legal guardian. If the patient is mentally or physically disabled, the spouse or parents may sign the form. If from **third party request**: Patient's consent is required.
2. **For Deceased patients**, MANDATORY documents that needs to be submitted are as follow:
 - i. A certified true copy of patient's death certificate
 - ii. A copy of a Letter of Administration, or a Grant of Probate, or 'Surat Pentadbiran Harta Pusaka', whichever applicable.
3. Please note that the release of medical information is subject to hospital management approval.

C. Patient's Particulars & Declaration

I, _____, NRIC/Passport No: _____ of
(Name of Patient/Parent/Next of Kin)

_____ hereby consent
(Address)

and authorize Gleneagles Kota Kinabalu to provide information contained in the medical records of *myself / patient.

Patient's Name: _____ NRIC / Passport No: _____

MRN: _____ Type of Admission : Inpatient Outpatient Emergency Others

Date of Visit : _____ to _____ for use for the
(Name and Address of Organization or Individual)

purpose mentioned below:

- Insurance Claim Continuity of Care Legal Purpose Others (please specify): _____

I further authorize Gleneagles Kota Kinabalu and its officers to release the medical report to:

to _____ NRIC/Passport No: _____
(Name and Address of Organization or Individual)

Contact No.: _____ Email Address : _____

who will receive this report on my behalf.

- Besides the medical report fees, I undertake to pay any additional charges such as laboratory reports or imaging reports, which may be incurred in the preparation of the report.
- With this, I release Gleneagles Kota Kinabalu, the attending doctors /consultants and its staff from all legal responsibilities or liabilities that may arise from the act hereby authorized.
- I shall irrevocably waive all my legal rights and remedies against Gleneagles Kota Kinabalu and shall not demand or claim against Gleneagles Kota Kinabalu for any loss, damage, expenses and/or costs which may arise from the act hereby authorized. I hereby agree to keep you indemnify against all actions, claims, proceedings, costs, damages and expenses (including legal costs on the full indemnity basis) which the said hospital may incur or sustain by reason of any of the above matters.

D. Method of Collection / Delivery

To Collect by Hand

Name of Person: _____ Tel. No _____

To Deliver by Post (Mailing)

Name of Person: _____ Tel. No _____

Postal Address: _____

To Email only

Email: _____ Tel No: _____

E. Signature

*Patient / Patient's Guardian / Next-of-Kin Signature
Date:

Signature & Name of Witness
Date: