Application for Disclosure of Medical Records

To Director of Japanese Red Cross Narita Hospital

I hereby apply for the disclosure of medical records as described below.

Date: (Y)/ (M)/ (D)

Applicant Name:

Signature:

Patient Information			
Name	(Previous family name if changed:)	Patient ID	*Leave blank if unknown.
Date of Birth	(Y)/ (M) / (D)		
Address	Post code: ―		
Phone	― ―	Email	

Disclosure Information			
Category	☐ Inpatient ☐ Outpatient	Period	From to
Department			
Disclosure Information	☐ Medical Record ☐ Image Data ☐ Examination Record ☐ Others ( )		
The way to receive	☐ Receive at the hospital ☐ Receive by mail to the applicant's address		
Remarks	(If you request disclosure of specific records only, please provide details.)		

*If the applicant is other than the patient, please attach the “Letter of Proxy for Disclosure of Medical Record” form.

Applicant Information			
Name		Relation to patient	
Address	Post code: ―		
Phone	― ―		
Email			
Category of proxy applicant	☐ 1) Family member or representative (when the patient appointed) ☐ 2) Guardian (when the patient is a minor) ☐ 3) Legal representative or voluntary guardian (if the patient has either one) ☐ 4) A person caring the patient (if the patient’s decision-making ability is in doubt) ☐ 5) Spouse, child, parent (if the patient is deceased) ☐ 6) A person appointed by the person explained in the above 2) – 5) ☐ 7) Other ( )		