REQUEST FOR RELEASE OF MEDICAL RECORDS/ INFORMATION

DECLARATION:

I declare that the information I will give are true and correct. I hereby release Insular Health Care, Inc. ("InLife Health Care") and its officers, employees and agents from any liability arising from any action taken based on this declaration.

_____	_____	_____
Signature above Printed Name (Thumbmark if unable to sign)	Date (MMM/DD/YYYY)	Time (0000H)

Date today (MMM/DD/YYYY)			
Name			
Contact Number		ID Presented	
Name of Company (OPTIONAL)			
Authorized Recipient (IF OTHER THAN THE REQUESTOR)		Designation	

TO THE CLIENT/ PATIENT: Kindly read all the information on this form before accomplishing and signing it. You may request the staff of Insular Health Care, Inc. ("InLife Health Care") to explain, or refer you to someone who can explain, your data privacy rights under RA 10173 or the Data Privacy Act of 2012.

By signing this consent form, I am specifically:

1. Authorizing InLife Health Care to release my medical records/information relevant or connected with my HMO coverage from, or of my diagnosis, treatment or availment of health care services at InLife Health Care EXCEPT the following:

   [Please check only the items pertaining to records/ information which you DO NOT permit to be released/ disclosed]:

   ☐ Drug/ Alcohol Abuse
   ☐ Mental Health/ Psychiatric Disorders
   ☐ Hepatitis
   ☐ HIV/ AIDS
   ☐ Tuberculosis
   ☐ Others: _____

2. Consenting to the processing of my sensitive personal information (including my medical records/ information) in accordance with applicable laws, regulations, and InLife Health Care's Privacy Policy, including its subsequent amendments, as stated in its website (www.insularhealthcare.com.ph/privacy-policy/).

ACKNOWLEDGEMENT: I hereby confirm that I understand the foregoing and that I am voluntarily giving my consent to the processing and release of my medical records/ information under the terms and conditions provided above. I understand that the consent I am giving through this form is in addition to any other consent that I may have already given InLife Health Care and its affiliates regarding the processing of my personal information (e.g. in relation to HMO coverage/ availment, examination, diagnosis, treatment or procedure). I likewise understand that the consent I have given shall remain in full force until revoked in writing except to the extent that action has already been taken based therein. I hereby release InLife Health Care from any liability arising from any processing and/or release of medical records/ information made in accordance with the consent I have given. A photographic copy of this authorization shall be as valid as the original.

[Maaaring tawagin ang pansin ng tauhan ng InLife Health Care kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]

_____	_____	_____
Client/ Patient's Signature above Printed Name (Thumbmark if unable to sign)	Date (MMM/DD/YYYY)	Time (0000H)

IF CLIENT/PATIENT IS A MINOR OR INCAPABLE TO GIVE CONSENT

_____	_____	_____
Signature above Printed Name (Thumbmark if unable to sign)	Relationship to Client/ Patient	Date (MMM/DD/YYYY)

Reason why the Client/ Patient cannot accomplish this form:

Reviewed by IHCI LEGAL