

**Saint Mary's Hospital Luodong**  
**Authorization to Retrieve Copies of Medical Records**  
**For The Use of Insurance Companies Only**

I, \_\_\_\_\_(the undersigned), hereby authorize the \_\_\_\_\_  
Insurance Company, Ltd. (hereafter refer to "COMPANY") to retrieve the medical records provided in  
writing from the Hospital. Requested items with this authorization are listed below:

1、Information of the requested individual

Name : \_\_\_\_\_

Birthday : \_\_\_\_\_(yyyy)\_\_\_\_\_(mm)\_\_\_\_\_(dd)

Identity number : \_\_\_\_\_

2、Relationship to the requested individual (Please check) (\*1)

- the person himself/herself
- interested party (Please also check one of the following items)
  - legal proxy
  - heir
  - guardian
  - assistant

3、Purpose of retrieval (Please check)

- Insure for commercial insurance
- Claim for settlement from commercial insurance
- Request for change of contract contents of commercial insurance (Please also check one of the following items) (\*2)
  - duty to inform
  - contract conversion
  - raise of insurance cover

4、Requested range of the medical records (Please check the item and complete its blanks)

- Request all outpatient records and emergency room records of \_\_\_\_\_ years (It should not be over 5 years) since \_\_\_\_\_(yyyy)\_\_\_\_\_(mm)\_\_\_\_\_(dd).
  - Please provide all the discharge summaries within the duration stated above if the requested individual also have had (an) admission(s) during the period.

Specified medical records

Requested duration: \_\_\_\_\_ years/months (It should not be over 5 years) since  
\_\_\_\_\_(yyyy)\_\_\_\_\_(mm)\_\_\_\_\_(dd).

Clinic Dept.: \_\_\_\_\_

(Please specify and it is not limited to one Dept.)

Disease: \_\_\_\_\_

(Please specify and it is not limited to one disease.)

Requested items (Please check one or more items)

- outpatient records and emergency room records
- discharge summaries
- laboratory reports
- nursing notes
- others (please specify) \_\_\_\_\_

5、Effective duration : 6 months from the effective date written on this authorization letter.

6、The COMPANY should not violate laws and infringe rights and interests of the undersigned, the requested individual, or others by the use of data, documents, information obtaining through this authorization. If the COMPANY breaches the terms stated above, the COMPANY should bear the legal responsibilities based on civil laws, criminal laws, administrative laws, etc.

The undersigned also agrees the following statements:

- 1、**Please check one of the statements below. If none of statements is checked, the Hospital only accepts the original authorization letter for the retrieval application.**
  - The COMPANY should provide the formal letter with the original authorization letter to the Hospital for the retrieval application.
  - The COMPANY could provide the formal letter with the copy of authorization letter to the Hospital for the retrieval application. It is required to add the statement within the quotation marks ("" ) below, "This copy is the same as the original. If there is any differences, the COMPANY should bear all the legal responsibilities", and affix the formal seal for the formal letter use to the copy. The undersigned agrees the copy has the same effectiveness as the original.
  
- 2、**The undersigned has known the contents of medical records authorized to be retrieved from this authorization letter may contain information regarding on communicable diseases of human immunodeficiency virus or others. The COMPANY should clearly explain to the undersigned with details in person to ensure that the undersigned understands the ranges and risks of this authorization and the undersigned having relevant rights of revocation.**
  
- 3、All controversies caused by the contents or effectiveness from this authorization letter are unrelated to the Hospital and the COMPANY shall bear all the responsibilities. The undersigned or the requested individual should not set up any claims to the Hospital.

To

Saint Mary's Hospital Luodong

Signature for this authorization: \_\_\_\_\_

Identity number: \_\_\_\_\_

Correspondence address: \_\_\_\_\_

Contact phone: (\_\_\_\_)-\_\_\_\_\_

COMPANY: \_\_\_\_\_

Correspondence address: \_\_\_\_\_

Contact person: \_\_\_\_\_

Contact phone: (\_\_\_\_)-\_\_\_\_\_

Effective date: \_\_\_\_\_(yyyy)\_\_\_\_\_(mm)\_\_\_\_\_(dd)

Note: \*1. If the applicant is the interested party, the applicant should also provide a copy of the undersigned's identity card and copies of supporting documents (Upon the applicant's identity, provide relevant documents such as the household certificate, registration-revoking household certificate, court decision, etc.) to prove there is legally interested to the requested individual that declares on this authorization letter.

\*2. "Duty to inform" means that the insurant should inform the insurance company if a new risk occurring or discovered influences the insurance company for risk evaluations after the insurance contract signed but before the insurance policy signed. "Contract conversion" means that the insurant requests to change the current insurance contract into other insurance contract under the same insurance company. "Raise of insurance cover" means that the insurant requests to increase the insured amount for the current insurance contract.