PHILIPPINE CHILDREN'S MEDICAL CENTER
Quezon Avenue, Quezon City
MEDICAL RECORDS AND LIBRARY DIVISION

ONLINE APPLICATION FOR MEDICAL INFORMATION FORM

Date of Request: _____

Patient's Contact Number: _____

Name of Patient: _____

Date of Birth _____ Sex: ☐ Male ☐ Female Date of Confinement: _____

Attending Physician: _____

Medical Information Needed:

☐ Clinical Summary/Abstract
☐ Photocopy of (please specify): _____
☐ Insurance Information
☐ Medical Certificate

Purpose of Request:

☐Justification for Absences of patient from school
Name of School: _____
☐Justification for Absences of patient's parent/s
Name of Office: _____
☐Insurance Purposes
Name of Insurance Company _____
☐Philhealth ☐ SSS ☐ GSIS ☐OWWA
☐Medical Assistance from: _____
☐Reimbursement of Expenses from: _____
☐Reference Purposes
☐Others

PRIVACY NOTICE/ STATEMENT

The PCMC Medical Records is committed to protect and respect your personal data privacy and confidentiality. Personal and sensitive personal information collected will be used solely for documentation and processing purposes and shall not be shared with any other parties. Only the PCMC Medical Records staff, Attending Physician and/ or authorized representative have access to your personal and sensitive personal information. The data will be stored in the database/ file for one (1) year after information requests are acted upon afterwhich physical record shall be disposed in compliance to the National Archives of the Philippines Act of 2007.

Affixing my signature below indicates that I have read and understood the privacy statement and I shall strictly follow the policies, procedures, and rules of the PCMC Medical Records Section including that of this document.

Requested by: **Approved by:**

_____ _____
Signature over Printed Name Consultant/Fellow/Chief Resident
Relationship to Patient _____ Date: _____

I hereby authorize the PCMC Medical Records Section to send my patient's document through:
E-mail please specify e-mail address _____

Thus I am releasing PCMC Medical Records in any legal obligation for any unforeseen or unexpected personal data breach.

_____
Signature over Printed Name

Relationship to Patient: _____