PHILIPPINE CHILDREN`S MEDICAL CENTER

Quezon Avenue, Quezon City

GUIDELINES AND INSTRUCTIONS FOR ONLINE APPLICATION FOR MEDICAL INFORMATION

1. This request is intended for in-patient or patient admitted at the Ward.
2. Download and fill-up the request form.
3. Email the scanned copy of the filled up request form and copy of any government issued ID of the parent/s as proof of relationship to the patient at medicalrecords@pcmc.gov.ph
   3.1. If the requesting party is the authorized representative, attach the following documentary requirement:
      3.1.1. Duly signed authorization from the parent (for minor) or the patient (for adult).
      3.1.2. Scanned copy or picture of any government issued ID of the parent and the authorized representative.
4. Wait for the acknowledgment e-mail from Medical Records to pay the corresponding amount in any Landbank branch or bank transfer to the:

   Account Name: PCMC
   Landbank Account Number: 0232-1161-53

5. E-mail back the copy of transaction slip or proof of payment to the Medical Records (medicalrecords@pcmc.gov.ph).
6. Requested documents will be e-mailed after 3 – 5 days, and shall only be available for 1 day upon access of the requester to ensure the privacy and confidentiality of the records.
7. Acknowledge receipt of the documents through the official e-mail address of the Medical Records Office.

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 after which 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:

____
Signature over Printed Name
Relationship to Patient ______________

Approved by:

____
Consultant/Fellow/Chief Resident
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: ____________

ETMR-PCMC-ORF13
200720 Rev. 0

CONTROLLED COPY
NO. QMO
BY: [signature] DATE: 7/20/20

MASTER COPY
NO. QMO
BY: [signature] DATE: 7/20/20