Consent Form for Disclosure of Personal Health Information

Suddhavej Hospital, Faculty of Medicine, Mahasarakham University

Date: ....

1. **Personal Information**: Name: ....Age: ....yr.
   Passport ID: .... Other documents (e.g., work permit): ....
   Date of document issuance: ....Issued by: ....
   Phone number: ....
   In the capacity of: ☐ Patient
   ☐ Authorized Representative. Relationship to the patient: ....
   Patient's name: ....
2. **Explanation of Consent**: I have been informed by Suddhavej Hospital, Faculty of Medicine, Mahasarakham University, about the purpose of providing consent for the exchange of personal health information. This includes the collection of relevant information such as, medical examinations, contact information, clinic registration, pregnancy information, dental information, vaccination records, laboratory information, drug allergies, as well as the risks and complications. This information will be used for the benefit of my health care.
3. **Consent for Disclosure**: ☐ **consent** to Suddhavej Hospital disclosing paper copy and electronic transmission of my health information for medical treatment or reimbursement to other authorized healthcare professionals, other healthcare facilities and reimbursement agent.
   ☐ **do not consent*** to Suddhavej Hospital disclosing paper copy and electronic transmission of my health information for medical treatment or reimbursement to other authorized healthcare professionals, other healthcare facilities and reimbursement agent.
4. **Limitations on Data Use**: If the healthcare facility uses my personal health information for purposes other than medical treatment and relevant reimbursement, consent on each agenda must be obtained, except when disclosure is required by law or court order.
5. **Right to Withdraw Consent**: I have the right to withdraw this consent. However, withdrawal does not affect actions taken before withdrawal. To withdraw consent, I must provide a written request, and I have the right to access, correct, delete, suspend, transfer, and object to the processing of personal data in accordance with the law.

Signature: .... Signature: ....

[Patient/Authorized Representative] [Hospital representative]

Witnesses: ....

[1st Witness]...[2nd Witness]

Note : PTO

Note:

The authorized representative may be:

1. A competent patient.
2. The spouse as defined by law, where one party is unconscious.
3. A representative acting fairly when the patient is not competent.
4. A legal guardian when the patient is incapacitated or incompetent.
5. A custodian when the patient is quasi-incompetent.

***In cases of non-consent**, the patient will still receive medical treatment. However, in cases where information needs to be transferred between hospitals (referral) for medical treatment, or in emergencies or special cases, the hospital must obtain consent from the patient or person providing consent before normal data transmission. This may cause delays or impact on the patient in case of referral to another healthcare facilities.