PUNYASHLOK AHILYADEVI HOLKAR
HEAD & NECK CANCER INSTITUTE
OF INDIA

CS NO. 254, Barrister Nath Pai Marg,
Dockyard Road,
Mazagoan, Mumbai 400010.
Contact no - 022 - 69450100
Web Site - https://hncii.org

APPLICATION FOR ISSUE OF MEDICAL RECORDS /INDOOR CASE PAPERS

To,

Date: - ☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

Medical Records Department
Head And Neck Cancer Institute of India,
Mazagoan, Mumbai 400010.

I, request Medical Records Department of Punyashlok Ahilyadevi Holkar Head And Neck Cancer Institute of India to issue the scanned copy pertaining to me/my patient's medical records as I need it only for following purpose.

(Please tick as applicable)

☐ Mediclaim ☐ Further Treatment ☐ Death Claim ☐ Medico legal ☐ Other (Please Specify)____

Patient Name:_____FIRST NAME_____MIDDLE NAME_____LAST NAME_____

Hospital IP No: _____ Contact No: _____

Date of Admission:_____ Date of Discharge: _____

Email ID:_____

☐ I understand that the Indoor case papers will be mailed to me on the email provide by me in this form

Applicant Name		Legal authorized representative Name:	
Signature		Signature	

INSTRUCTION FOR RELEASE OF MEDICAL RECORDS

The Punyashlok Ahilyadevi Holkar Head And Neck Cancer Institute Of India, Mumbai requires a completed and signed written request & authorization for release of Medical Records/ Indoor Case papers before releasing documents to anyone including the patient.
Please read the instructions for release of medical records. If you have any queries, you can reach us on 022 - 69450100 Ext-0201

1. Patient or authorized representative whose name is mentioned as legal authorized representative in hospital records may obtain a scan copy of his/her medical records. The patient or Authorised attendant must date and sign.
2. If the patient is minor (under age 18) , authorized representative must sign on his/her behalf.
3. If the patient is over 18 years and is incompetent, the authorized representative must sign and provide proof of legal representative.
4. If the patient is deceased, the authorized representative or legal representative must sign & provide proof of legal representation.
5. Indoor case papers it will be e-mailed to registered E-mail Id shared on this request form.

FOR OFFICE USE ONLY

Remark: Approved/Not Approved Signature_____	Date of Issuing_____ Medical Records_____ Medical Records Issuers Signature	Received photo copies of Indoor Case papers/Med Records Receivers Name:_____ Receivers Signature_____