SAMSUNG MEDICAL CENTER

CONSENT: MEDICAL RECORD READING AND COPY

Patient	Name	Contact number
	Date of Birth (Alien registration number)	
	Address	

Applicant	Name	Relationship to patient
	Date of Birth (Alien registration number)	Contact number
	Address	

Range of reading and copy	Name of hospital
	Consultation period
	Purpose of medical record reading and copy

I (or legal representative) agree that the above applicant is allowed to read or request the copy of my medical record according to the 「medical law」 in article 21, section 2 and the same law of enforcement regulation in article 13, section2.

Date (yyyy/mm/dd) _____

Patient's name (or legal representative) _____

Signature _____