Medical Treatment Authorization Form

Request for Medical Services

Part A (Company)

Company Name 公司名稱 ______________________________

Project Title 地盤名稱 ______________________________

Authorized Name and Title 負責人姓名及職位 ______________________ Signature 簽名 ______________

Company Stamp 公司印 ______________________

Date 日期 ______________________

Part B (Patient)

I hereby authorize TY Medical Practice, or its medical and nursing personnel, to furnish to the above company, or its representative(s), any and all information with respect to my illness, medical history, consultation, prescriptions or treatment. A photocopy of this authorization shall be considered as valid as the original.

本人謹授權天一醫務所或其醫護人員可向上述公司或其代表提供有關本人之部份或全部健康紀錄及治病詳情。本人明白此授權書之影印本與正本功能無異。

Signature 簽名 ______________________

Name 姓名 ______________________

Date 日期 ______________________

Part C(Doctor)

☐ First Consultation ☐ Follow-up Consultation

Diagnosis ______________________________

Doctor's Name & Signature ______________________ Date ______________________

Chun Wo Head Office Use

Case No.: ______________________