Authorization for Disclosure or Copies of Medical Records 진료기록 열람 및 사본발급 위임장

	Name	Contact Number
Delegated _	Foreign Registration Number	Relationship to Delegating Person
Person	rvuilibei	Delegating 1 crson
	Address	
	Name	Contact Number
Delegating	Foreign Registration	
Person	Number	
(Patient)	Address	

I grant all authority to the above delegated person to obtain medical records in such manner as stated in the 「Consent for disclosure or copies of medical records」, in accordance with Clause 3 of Article 21 of the 「Medical Service Act」 and Article 13-3 of the Enforcement Rules of the same Act.

Date 20__ / __ / __ (yyyy/mm/dd)

Delegating Person (Signature)