Consent for Disclosure or Copies of Medical Records

진료기록 열람 및 사본발급 동의서

<table>
<tr><td rowspan="3">Patient</td><td>Name</td><td></td><td>Contact Number</td><td></td></tr>
<tr><td>Foreign Registration Number</td><td colspan="3"></td></tr>
<tr><td>Address</td><td colspan="3"></td></tr>
<tr><td rowspan="3">Applicant</td><td>Name</td><td></td><td>Relationship to Patient</td><td></td></tr>
<tr><td>Foreign Registration Number</td><td></td><td>Contact Number</td><td></td></tr>
<tr><td>Address</td><td colspan="3"></td></tr>
<tr><td rowspan="3">Scope of disclosure and copies</td><td colspan="4">Name of medical institution</td></tr>
<tr><td colspan="4">Period of medical treatments</td></tr>
<tr><td colspan="4">Content and reason for disclosure or copies of medical records</td></tr>
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I, as the patient (or a legal representative of the patient), hereby request that any of my medical records and related information pertaining to my treatment should be released to the above applicant ( ) in accordance with Clause 2 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)

Patient(or legal representative) (Signature)

Note : If the patient is under age 14, his/her legal representative shall sign this form.