AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

AlKoot INSURANCE & REINSURANCE
الكوت للتأمين و إعادة التأمين
Licensed by Qatar Central Bank

PATIENT DETAILS
Section to be filled by the Patient/Guardian

PATIENT'S NAME:	
DATE OF BIRTH:	**GENDER:** ☐ Male ☐ Female
QID NUMBER: PASSPORT NUMBER IF QID NOT AVAILABLE	**ALKOOT ID NUMBER:**
MOBILE NUMBER:	**EMAIL ADDRESS:**

ORGANIZATION/PERSON DETAILS TO WHOM ABOVE INFORMATION CAN BE RELEASED
Section to be filled by the Patient/Guardian

NAME OF ORGANIZATION/PERSON:

Al Koot Insurance & Reinsurance Company; P.J.S.C
Address: Building No: 44, Street No: 840, Zone No: 24
Al Rawabi Street, P.O.Box 24563
Doha – Qatar

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I, the undersigned, hereby fully authorize AlKoot Insurance & Reinsurance company to release my personal and medical information to an organization/persons listed in this authorization. I understand that the records may contain full medical details including but not limited to full medical reports, laboratory & diagnostic results, doctors' notes, details of the medical facilities & treating doctors, diagnosis and full history of treatments and services taken. I understand that I may inspect and have copies of the information I am releasing. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use or disclosure of the information identified in this authorization is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to AlKoot Insurance & Reinsurance company. I release AlKoot Insurance & Reinsurance from all legal responsibility and liability for the information release according to the terms of this written authorization. As per Law No. (22) of 2021 Regulating Healthcare services within the State of Qatar, all parties are obliged to maintain the privacy and confidentiality of any disclosed information.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

SIGNATURE
Section to be filled by the Patient/Guardian

PATIENT'S/GUARDIAN'S NAME:	PATIENT'S/GUARDIAN'S SIGNATURE
DATE:	

GUARDIAN DETAILS
Section to be filled in case of Guardian Signing the Authorization

RELATIONSHIP TO THE PATIENT:	QID NUMBER/PASSPORT NUMBER (For Guardian)

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