BANGKOK HOSPITAL
KHON KAEN

Name: …… Room: ……
HN: …… Physician: ……
Visit Date: …… Department: ……
Birth Date: …… Age: …… Gender: ……
Allergies: ……
Side effect: ……
ID: ……EN: …… Blood group ……
Address: ……

General Consent Form for investigation and treatment and Consent Form for Collection, Usage and Disclure of Patient's Health Information

I (Mr./ Mrs./ Miss) _____, age _____

Identification Number/ Passport Number_____

I understand that___(Specify name of "Hospital") ____conducted a business by____(Specify name of "Company") ___ [hereinafter referred as "Hospital'] is required by law to protect my personal health information and enable to disclose the information as deem necessary.

Obligation to protect and secure patient's personal health information and reasonably disclose the information as deem necessary.

The hospital has professional and legal obligations to protect and secure patient's personal health information. According to the Personal Data Protection Act B.E. 2550 and the Personal Data Protection Act B.E. 2562, patient's personal health information is described as personal data. The disclosure of patient's personal health information without consent is restricted unless required by law. However, to maintain the hospital's medical service standard and to respect the patient's privacy, the Hospital deems necessary to disclose the patient's personal health information to the physicians, nurses, medical personnel and/ or other staffs in the team of Hospital to investigate, treat or perform other practices in accordance with professional principles for benefit of investigation and treatments for patient's illness. The hospital shall follow the related protocols and laws for protecting and securing the patient's personal health information as priority. I was informed about estimated cost of hospitalization and clearly understood

☐ Acknowlege

I hereby give my consent to the Hospital to provide investigation and treatment for my illness and to disclose my personal health information in various matters as below:

1. Consent for general investigation and treatments

I voluntarily give my consent to physicians, nurses, medical personnel and/ or other staffs in the team of the Hospital to investigate, treat or perform other practices in accordance with professional principles for my benefit of investigation and treatments for my illness. I have adequatedly been informed and well understood about health information related to the investigation and treatments as well Declaration of Patient's Right, including receiving a copy of Patient's Rights and Patient's Responsibilities.

☐ Consent ☐ Refuse

2. Consent for Collection, Usage and Disclosure of Personal Data

2.1 For the purpose of indemnity claim from insurance company or medical welfare from the third party payer either a person or juristice person in Thailand or overseas.

I give my consent to the Hospital to disclose and/or send a copy of my personal data records of the Hospital to an insurance company or a dedicated person of the insurance company to comply with the terms of the contract that I have been engaged in or will be engaed in, including the third party payor, contract hospital, person, juristic person, government party, private section or state enterprise in both Thailand or overseas that refers me to undergo investigation at the Hospital or take responsibility for my medical expenses.

☐ Consent ☐ Refuse

2.2 For the purpose of an personal data access for me or the team of the Hospital or its network[1] that I have been treated for my best benefit of treatment.

I voluntarily give my consent to the Hospital to manage my personal health information for my benefit of data access in network hospitals that I have a treatment. The medical team in network hospital has a right of reasonable access to my personal health information for the most appropriate treatment plan.

[1] Netowork hospitals means the hospitals in network of Bangkok Dusit Medical Services PLC in Thailand and overseas.

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☐ Consent ☐ Refuse

2.3 For the purpose of marketing activity of the Hospital

I voluntarily give my consent to the Hospital for collection, usage and evaluation of my health condition analysis and to contact for offering products and services related with my health condition. I also voluntarily give my consent to the Hospital for contacting, communicating, sending medical newsletter or printed matter and offering products and services to myself.

☐ Consent ☐ Refuse

I, understand, do hereby agree and give my consent.

Patient's Name (Printed name)	Signature	Date	Time (Hrs.)
Witness's Name (Printed name)	Signature	Date	Time (Hrs.)
Second Witness's Name (Only if finger print use) (Printed name)	Signature	Date	Time (Hrs.)
Physician od Dentist's name or Designee (Printed name)	Signature	Date	Time (Hrs.)

State the reason the patient is not able to give consent personally (or the self sign on this form)

☐ Minor - any unmarried male of female whose age has not reached the age of consent (20 years old)

☐ Physical / mental disorder

☐ Other (Please specify) _____

Above information has completely been explained to legally authorized representative (as name below) who has acknowledged and hereby given the consent for the mentioned treatments.

Legally authorized representative LAR's Name (Printed name)	(LAR)'s Signature	Date	Relationship
Identification No.	Issue Place	Issue Date	Expiration Date

Current Address