OPT OUT FORM OF HEALTH INFORMATION SUBMISSION TO MALAYSIA HEALTH INFORMATION EXCHANGE (MyHIX) MINISTRY OF HEALTH MALAYSIA

Hospital / Klinik ……..

I ……
(name of *patient / parent / guardian / next of kin)

hereby, do not agree that the health information of *myself / my child / person under my care:

Name of Patient: ……

MRN: ……

Patient Identification No.: ……..

to be submitted to MyHIX for the purpose of sharing health information between the healthcare facilities for current treatment session only.

I will not undertake any action towards the hospital / clinic / Ministry of Health Malaysia / Government of Malaysia should any injury, inconvenience, loss or other consequences occur to myself / my child / person under my care due to the exclusion of health information submission to MyHIX.

Date: ……

Signature: ……..
*(Patient / parent / guardian / next of kin)

Relationship (if appropriate): ……..……

Identification Number:..……

Date: ……

Signature of witness: ……

Name: ……..

Designation: ……..

Identification Number:..…….

*Strikethrough where inappropriate