



PATIENT PROFILE AND CONSENT FORM

LAST NAME:

FIRST NAME:

MIDDLE NAME:

SUFFIX (JR., SR., III, etc.):

BIRTHDAY:

MM

DD

YYYY

ADDRESS:

HOUSE NO.

LOT NO.

BLOCK NO.

STREET NAME

VILLAGE/SUBDIVISION/BARANGAY

CITY/MUNICIPALITY

GENDER:

MALE

FEMALE

CONTACT DETAILS:

E-MAIL ADDRESS _____

NATIONALITY _____

HOME PHONE _____

CIVIL STATUS _____

WORK PHONE _____

OCCUPATION _____

MOBILE PHONE _____

EMPLOYER/CORPORATION _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSHIP _____

CONTACT NO. _____

Private Patients:

I will pick up the results myself

Please send results to the e-mail address supplied above.

A representative with an authorization letter and ID will pick up the results.

Please send results to Makati LGU for Sanitary Permit

I understand that the security and reliability of obtaining the results through means other than personal pick-up cannot be guaranteed. I hereby hold FORTMED, its officers, directors, stockholders, employees, consultants, and doctors free from all claims, suits, charges, fees, damages, or liabilities arising from or connected with the release of the medical records by these means.

Corporate/HMO/Insurance Patients:

Results of medical tests required by my employer/potential employer/insurance company may be sent to them directly as instructed in the LOA/Referral Slip and/or to the local government unit (LGU) for purposes of the employer's application for Sanitary Permit. I hereby authorize FortMED to disclose to my employer/potential employer/insurance company and/or to Makati LGU, results of the tests and procedures undertaken. I hereby hold Fortmed free from claims and damages arising from such disclosure.

By submitting this form, I hereby consent and confirm to the lawful collection, use, disclosure, retention, and disposal of FortMED of the personal and sensitive personal information in accordance with the Privacy Policy of FortMED, accessible through <http://www.fortmed.org/web/patient-privacy/>.

Patient's Signature over Printed Name

Date

FORTMED MEDICAL CLINICS

CONSENT FORM

In compliance with Republic Act No. 10173, otherwise known as the "Data Privacy Act", Fortmed Medical Clinics ("FORTMED") seeks your consent to collect, process, store, and use your personal data ((age, residence, employment details, HMO details, Philhealth details, contact details, medical history), results of physical and diagnostic examination such as, but not limited to complete blood count, blood chemistry, urinalysis, fecalysis, chest x-ray, ECG, pap smear, drug test and any other information related to your visit to FORTMED, as part of your consultation, diagnostics, pre-employment physical examination, annual physical examination, or executive check-up ("PPE/APE/ECU"), as a private individual or as an employee/officer of _____ (the "Corporation").

FORTMED intends to collect your personal information to provide its service, which information shall be used and processed by all personnel, consultants and third-party service providers connected with FORTMED. After every examination, FORTMED will generate reports from the data collected which FORTMED will send to you, the Corporation, or to third party you authorize it to send to. For this purpose, your information will be stored by FORTMED for a period of ___ years, without prejudice to your rights to reasonable access to, upon demand, and correction of your personal information, as well as your right to lodge a complaint before the National Privacy Commission, under Section 16 of the Data Privacy Act. (For more information on your rights, please see <https://privacy.gov.ph/know-your-rights/>). FORTMED implements measures to protect the personal information you provide, in accordance with its privacy policy, which the Corporation likewise adopts. (For more information, please see <https://www.fortmed.org/web/wp-content/uploads/Fortmed-Privacy-Policy-03.08.2022.pdf>). Should you wish to access, correct or update the personal information you have provided, or if you have any further questions about the use of your personal information, please write us at dataprotection@fortmed.org.

I have read the above information, including FORTMED's privacy policy and the Data Privacy Act, and understand the reasons for the collection of my personal information and the ways the information may be used and disclosed, and I agree to said usage and disclosure.

I understand that it is my choice as to what information I provide, and that withholding or giving false information might act against the best interests of my medical assessment/diagnostics.

I understand that the information I provide will be processed and sent to the Corporation for whatever legitimate purpose it may serve and/or to the local government unit through its portal for purposes of the Corporation's application for Sanitary Permit.

I hereby authorize FORTMED to release all medical records and related documents and information derived from diagnostics, laboratory services and medical consultation with the FORTMED including a summary thereof, for whatever legitimate purpose it may serve. In the same manner, I am giving the Corporation full and unrestricted access to my personal data.

I hold FORTMED, its officers, directors, stockholders, employees, consultants, and doctors free from all claims, suits, charges, fees, damages, or liabilities arising from or connected with the release or disclosure of the medical records. I also hold FORTMED, its officers, directors, stockholders, employees, consultants, and doctors free from all claims, suits, charges, fees, damages, or liabilities from any hiring decision made by the Corporation.

I am aware that I can access my personal and diagnostic/treatment information upon request and if necessary, to correct information that I believe to be inaccurate. Further, I understand that if, in exceptional circumstances, access is denied for any legitimate purposes, the reason for this and possible remedies will be made available to me.

Signature over Printed Name

Date

Confidentiality Notice: FORTMED will not disclose any information obtained in the conduct of the PPE/APE/ECU, except as otherwise provided herein, subject to the provisions of the Data Privacy Act. Further, FORTMED guarantees that information that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Disclaimer: If you have any question regarding results, a medical condition or any of the data contained therein, you may seek a second opinion from your physician or other qualified health provider. It is hereby understood that FORTMED shall not be held liable for any injury or damage arising from laboratory results and diagnosis it issued. Neither shall FORTMED be liable in any way for the hiring/employment decisions of the Corporation.

Waiver: I certify that the information I provided in the Patient Profile and Consent Form and the statements made by me in answer to the questions in the PPE/APE/ECU are true and correct to the best of my knowledge and belief. I understand that I am required to complete all medical test stated in the LOA/Referral Slip within seven (7) days at Fortmed Clinics. I understand that my failure to complete these tests may result in delayed and incomplete medical files and inaccurate medical assessment.

Signature over Printed Name

Date