

**FORM - 'A'**  
**REQUEST BY PATIENT**

IP No. \_\_\_\_\_ HFH No. \_\_\_\_\_

Read the form carefully  
before filling.

\* Strike out inapplicable.

Name of Patient: \_\_\_\_\_

Address of Patient: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

To-  
Medical Director / Medical Superintendent,  
Holy Family Hospital, Bandra (W),  
Mumbai, 400050

Request for:-

INDOOR CASE PAPERS

OTHERS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Tick what is required**

Dear Sir/ Madam,

I, the undersigned Mr. / Mrs. / Ms. / \_\_\_\_\_  
\_\_\_\_\_ was admitted to your hospital on \_\_\_\_\_ and (still in hospital ) /  
discharged on \_\_\_\_\_ . I request you to make above documents  
available to me on payment of your schedule charges for my \*Insurance / Further  
treatment / Legal / Record / other \_\_\_\_\_ **(please specify  
the purpose)**.

I hereby authorize Mr. / Mrs. / Ms. \_\_\_\_\_  
\_\_\_\_\_ my \_\_\_\_\_ **(relation with the patient)**  
whose signature is given below and attested by me.

Authorized person's

Signature : \_\_\_\_\_

Name : \_\_\_\_\_

Relationship with Patient : \_\_\_\_\_

\_\_\_\_\_

MRO,  
Pls. give the documents -

Medical Director /  
Medical Superintendent

Yours faithfully,

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Name in block letters