FORM – 'A'
REQUEST BY PATIENT

IP No. _____ **HFH No.** _____

Name of Patient: _____

Address of Patient: _____

_____

_____

_____

Date: _____

Read the form carefully before filling.
* Strike out inapplicable.

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