

FORM - 'B'
REQUEST BY PATIENT'S
NEXT OF KIN
IN CASE OF PATIENT HAS
EXPIRED

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
 DEATH SUMMARY
 OTHERS (please specify) _____

Tick what is required

Dear Sir,

I, the undersigned Mr. / Mrs. / Ms. / _____

* Father / Mother / Husband / Wife / Son / Daughter / Brother / Sister / Other ____

_____ of the patient Mr. / Mrs. / Ms. _____

_____ who was admitted to your hospital on _____ and

expired on _____ . His / Her body was claimed by me from the hospital.

Since, I am patient's legal heir, I wish to have these documents on payment of your
schedule charges for *Insurance / Death claim / 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

Yours faithfully,

Signature : _____

Signature :

Name : _____

Relationship with

Name : _____

Patient : _____

Relation with Patient : _____

MRO,
Pls. give the documents -

Medical Director /
Medical Superintendent