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 : _____

_____

_____

_____

Read the form carefully before filling.

* Strike out inapplicable.

Date : _____

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

Signature : _____

Name : _____

Relationship with Patient : _____

Yours faithfully,

Signature :

_____

Name : _____

Relation with Patient : _____

MRO,
Pls. give the documents -

Medical Director /
Medical Superintendent