

OPT OUT FORM OF HEALTH INFORMATION SUBMISSION TO MALAYSIA HEALTH INFORMATION EXCHANGE (MyHIX) MINISTRY OF HEALTH MALAYSIA

Hospital / Klinik

hereby, do not agree that the health information of *myself / my child / person under my care:

Name of Patient:
MRN:
Patient Identification No.:

to be submitted to MyHIX for the purpose of sharing health information between the healthcare facilities for current treatment session only.

I will not undertake any action towards the hospital / clinic / Ministry of Health Malaysia / Government of Malaysia should any injury, inconvenience, loss or other consequences occur to myself / my child / person under my care due to the exclusion of health information submission to MyHIX.

Date:	Signature:
	Relationship (if appropriate):
	Identification Number:
Date:	Signature of witness:
	Name:
	Designation:
	Identification Number:

*Strikethrough where inappropriate