Waiver and Consent for Release of Confidential Patient Health Information

I, _____, with Patient Code No. _____
(Name of Patient)

of legal age and presently undergoing anti-retroviral therapy hereby authorize:

_____ of _____
(Name of Attending Physician) (Name of Accredited HIV Treatment Facility)

to release the following information from my medical records to PhilHealth:

- ☐ Photocopy of confirmatory test result
- ☐ Health regimen booklet or electronic health regimen summary
- ☐ Referral letter
- ☐ Others: Specify_____

The above information is to be released strictly to the authorized representatives of the Philippine Health Insurance Corporation (PhilHealth) for the purpose of benefit availment.

By signing below, I request that payment of PhilHealth benefits for the Outpatient HIV/AIDS Treatment Package be made on my behalf to the aforementioned treatment facility for services provided to by the facility and its staff.

I undertake to release PhilHealth and its employees from any and all liabilities relative to the release of the above-enumerated information.

Name of Patient or Person Acting on Patient's Behalf	Signature	Date

Reasons for Signing on Patient's Behalf: _____

Name of Attending Physician	Signature	Date

Witness Printed Name	Signature	Date

MASTER COPY
DC: Date: 12/17/2021