Ministry of Health - State of Israel **מדינת ישראל – משרד הבריאות**
THE JERUSALEM MENTAL HEALTH CENTER **המרכז הירושלמי לבריאות הנפש**
Affiliated with The Hebrew University – Hadassah School of Medicine, Jerusalem
מסונף לביה"ס לרפואה של האוניברסיטה העברית והדסה, ירושלים

Waiver of medical confidentiality

To: The Jerusalem Mental Health Centre

I, the undersigned, do hereby authorize the Jerusalem Mental Health Centre to transfer and/or give to:

_____

all details, without exception, concerning my medical condition and/or the diseases from which I suffered and/or am currently suffering, including psychiatric or mental treatments, and do hereby release you and/or your employees and/or anyone acting on your behalf or upon your instructions, from the duty of medical confidentiality in all matters concerning the transfer of information concerning my medical condition and/or diseases from which I suffered and/or am suffering as aforementioned. I hereby waive my right to medical confidentiality, and will have no complaint or claim of any kind concerning the transfer of the aforementioned medical information.

Personal details of the person making this waiver:

_____
First name Surname I.D. Number

_____
Address Date

Signature

Personal details of the witness to the signature (lawyer, doctor, social worker, nurse, psychologist, medical records clerk)

_____
First name Surname

_____
Position License number Stamp & Signature

For official use by the centre for medical information (medical records) and/or the transmitting unit

Description of the information transmitted		
Name and signature of the recipient		Date
Details of the transmitter		

ויתור סודיות רפואית/ 2007

דואר נע צפון יהודה 90972
D. N. Zfon Yehuda 90972
טל: 02-5705111 :Tel פקס: 02-5340084 :Fax

גבעת שאול ב', ירושלים 91060
Givat Shaul,Jerusalem 91060
טל: 02-6551551 :Tel; פקס: 02-6551552 Fax

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Request for provision of medical information

To: Date:_____

Re: (Patient's name & I.D. Number) _____

Is currently a patient in the Jerusalem Mental Health Center.

For the purposes of efficient care of the patient we request that you provide us the following information

_____

All information provided by you will constitute part of the patient's medical records and will be subject to all regulations
concerning medical confidentiality. We request that you provide the information to:_____

Sincerely,

_____

Waiver of medical confidentiality

I, the undersigned, do hereby authorize (name of institution or providing caretaker):

_____

to provide the Jerusalem Mental Health Centre, details, without exception, concerning my medical condition and/or any diseases from which I suffered and/or am currently suffering, including psychiatric or mental treatments received, and do hereby release you and/or your employees and/or anyone acting on your behalf or upon your instructions, from the duty of medical confidentiality in all matters concerning my medical condition and/or diseases, as aforementioned. I hereby waive my right to medical confidentiality, vis-à-vis the Jerusalem Mental Health Centre, and will have no claim or complaint of any kind concerning the tranfer of the aforementioned medical information.

Personal details of the person making this waiver:

_____

First name Surname I.D. Number

_____

Address Date Signature

Personal details of the witness to the signature

_____

Stamp & Signature

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