

If any of the following conditions below apply, please complete this form.

1. In the event that your personal representative apply for receiving any medical certification.
2. In the event that your personal representative receive any medical certification.

Personal Representative Designation Form

year month date

To Hiroshima University Hospital

Patient

Name : _____

Date of Birth : _____ year month date

TEL Number : _____

*If it is difficult to fill in this form in person, a person who is not your personal representative can write instead of a patient and need to fill in the blanks below.

Name : _____ [Relationship to patient: _____]

The reason writing this form instead of a patient:

I(Patient) designated a person below as my personal representative who has a right to act on behalf of me with apply for and receive my medica record, certificate, etc.

Personal Representative

Name : _____

Adress : 〒 _____

TEL Number : _____

NOTE :

1. A personal representative needs to bring your identification card such as passport, driver license, Japanese insurance card, etc.
2. This letter must be written within 6 months.
3. It is only valid original document.