

## **CONSULTATION FORM**



Dear Doctor, for your prescription, you are kindly requested to fill the Prescription/Advice Form along with عزيزي الطبيب ، لوصفتك الطبية ، نرجو منك تعينة نموذج الوصفة مرفقا مع هذا النموذج this form.

## PATIENT INFORMATION

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توقيع وختم الطبيب

المرافق المرافق المرافق العلم العالم	PATIENT NAME		: JC	DANNE MARIE EL	. HOYEK				
الجنس الجدالة الميلاد (CARD MRR : 2NNF-NN3F-LFLH-NLED PAYER : NAS VN الطاقة الميلاد ا	اسم المريض								
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DOCTOR'S SIGNATURE AND STAMP DATE: 04/08/2025	DOCTOR'S SIGN	ΔTI	JRE AND ST			Specialist Obstetrics And DHA No: 7538595	Gynecology 55-001 ENTER LLC	DATE: 04/08/	2025

التاريخ

I hereby authorize any healthcare provider or Insurance Company to provide and/or give copies of medical records to NAS Personnel in relation to current or previous treatments and services rendered to myself or any of my dependents. Any copy of this consent shall be considered as the original.

أنا الموقع أدناه ، أفوض أية جهة طبية أو طبيب أو شركة تأمين بتزويد شركة ناس بأي معلومات من الملف الطبي بشأن العلج الحالي أو السابق لي أو للفراد المعالين من قبلي و الحصول على صورة منه. اية صوره عن هذا التخويل تعتبر كالصليه

BENEFICIARY'S SIGNATURE	
توقيع المستفيد	