श्री चित्रा तिरुनल आयुर्विज्ञान और प्रौद्योगिकी संस्थान, त्रिवेंद्रम, तिरुवनन्तपुरम - 695 011, केरल, भारत
SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES AND TECHNOLOGY, TRIVANDRUM
THIRUVANANTHAPURAM - 695 011, KERALA, INDIA
(एक राष्ट्रीय महत्व का संस्थान, विज्ञान और प्रौद्योगिकी विभाग, भारत सरकार)
(An Institution of National Importance, Department of Science and Technology, Government of India)
Phone: 91-471-2443152 **Email:** sct@sctimst.ac.in

CONSENT FORM FOR ISSUING / SHARING OF HEALTH INFORMATION

HEALTH INFORMATION TO BE ISSUED / SHARED

☐ Complete medical record (OP / IP)
☐ Discharge summary
☐ Diagnostic reports (Lab / Radiology / Cardiac)
☐ Prescriptions / treatment details
☐ Operative / procedure notes
☐ Medical / fitness certificate
☐ Other: _____

Period covered: From ___ / ___ / _____ To ___ / ___ / _____

PATIENT LABEL

TO WHOM THE INFORMATION IS ISSUED / SHARED

☐ The patient himself / herself
☐ Legally authorised representative: _____
☐ Another healthcare provider: _____
☐ Insurance company / TPA: _____
☐ Employer / Govt. authority: _____
☐ ABDM / National Digital Health Ecosystem (via ABHA)

PURPOSE OF SHARING

☐ Continuity of care / referral / second opinion
☐ Insurance claim / reimbursement
☐ Medico-legal / statutory requirement
☐ Personal use of the patient
☐ Research / academic use (de-identified, with Ethics Committee approval)
☐ Other: _____

MODE OF ISSUE / SHARING

☐ Hard copy
☐ Electronic (email / ABDM-enabled app / secure portal)
☐ Direct transfer to the recipient

PATIENT'S UNDERSTANDING AND DECLARATION

I, _____ (name of patient / legally authorised representative), state that:

- I have been provided with the Privacy Policy and Privacy Notice of Sree Chitra Tirunal Institute for Medical Sciences and Technology (the "Institute"), also available on its website **www.sctimst.ac.in**, and have understood their contents.
- I understand that my personal data may be collected only with my valid consent, and used, processed or disclosed by the Institute, the Ayushman Bharat Digital Mission (ABDM) or its ecosystem partners only in accordance with the ABDM Health Data Management Policy and the Institute's Privacy Policy and Privacy Notice.
- I understand that my personal data may be shared across entities within the National Digital Health Ecosystem only with my consent and only for the purposes recorded above, and that it will be kept confidential and protected with reasonable security safeguards.
- I understand that, as a data principal, I have rights over my personal data relating to confirmation and access, correction and erasure, objection to disclosure, and portability, available in the manner set out in the ABDM Health Data Management Policy and the Institute's Privacy Policy and Privacy Notice.
- I understand that the terms of the Privacy Notice may change, that I will be notified before or at the time of any further collection, use or processing of my personal data, and that I will be given the opportunity to provide fresh consent.
- I understand that I may revoke this consent at any time in the manner specified in the Privacy Notice. Revocation will not result in any penalty or loss of benefits to which I am otherwise entitled from the Central or State Government or any healthcare provider, and will not affect information already shared.
- I understand that refusing consent will not affect the quality of care provided to me at the Institute, except where disclosure is required by law.
- I have had the opportunity to ask questions, all of which were answered to my satisfaction, and I give this consent voluntarily and without coercion.

Original to be filed in the patient's medical record. A copy is to be given to the patient.

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CONSENT

Having read (or having had read and explained to me) and understood the points mentioned above, I consent to the Institute collecting, using, sharing or processing such personal data and health information as is necessary for the purposes recorded in this form.

I understand and agree that the Institute will do so in accordance with the ABDM Health Data Management Policy, the Institute's Privacy Policy and Privacy Notice, any information security policy, data archival and retention guidelines, any other policy notified from time to time for their implementation, and any other applicable law.

Consent valid till: Date ____ / ____ / _____ Time ____ : ____ *(or until revoked, whichever is earlier)*

Signatory	Name	Signature / Thumb impression	Date & Time
Patient			
Legally authorised representative (if patient is a minor or unable to consent)			
Relationship with patient: _____			
Reason for consent by representative: _____			
For patients who cannot read: the contents were read out and explained in _____ (language) by _____, and the patient appeared to understand them.			

DECLARATION BY HOSPITAL STAFF

I have explained the nature, purpose, recipients and consequences of sharing the above information to the patient / representative in a language they understand, and have obtained consent voluntarily.

Name of Staff	Designation	Employee Code	Signature	Date & Time

FOR OFFICE USE

Information issued / shared on (date & time)		Issued / shared by (name & signature)	
Received by (name, relationship & signature)		ID proof verified (type & number)	
Consent revoked on (date & time)		Revocation recorded by (name & signature)	

Original to be filed in the patient's medical record. A copy is to be given to the patient.