



Our Claim Ref:

Date:

**TO WHOM IT MAY CONCERN**

Dear Sir/Madam

**CONSENT ON RELEASE OF INFORMATION**

I, \_\_\_\_\_ with NRIC No. \_\_\_\_\_  
address at \_\_\_\_\_

hereby authorize **MAA Takaful Bhd** to obtain any records or knowledge of me/ participant or my/our health information from any physician, hospital, clinic, Takaful Operator/ Insurance Company or other organization, institution or person. The said information is required in connection with a Takaful claim.

With this I release the said physician, hospital, clinic, Takaful Operator/ Insurance Company or other organization, institution or person and its staff from all legal responsibilities and liabilities that may arise from the act hereby authorized.

Thank you.

Yours faithfully

\_\_\_\_\_  
(Signature / Thumb Print)

( \_\_\_\_\_ )

Witnessed by :-

Signature : \_\_\_\_\_

Name : \_\_\_\_\_

NRIC No. : \_\_\_\_\_