





Male
DOB: 22/03/2006
-NIL-
AKSHAY MALLICK
MAYA MALLICK
MASSION
Male: 2 Female: 1 Total: 3 Expired:
MUCOPOLYSACCHARIDOSIS DISEASE TYPE-II (MPS-II)
INSTITUTE OF CHILD HEALTH (ICH)
DR. SANA ISLAM
8100614274
Phone No /Mobile 1: 9874487942
PhoneNo/Mobile 2: 7003229345
STD Code if landline
Email ID 1:rvforg@yahoo.com Email ID 2:
Landmark: 58, BUS STAND
City : HOWRAH
Taluka :676, SARAT CHATTERJEE LANE
D,istrict : HOWRAH
PIN code :711102



Permanent Address if it is different from above	Landmark: 58, BUS STAND City : HOWRAH
	Taluka : 676, SARAT CHATTERJEE LANE
Referred by and Contact	District : HOWRAH PIN code :711102(W.B)
Details	
Remarks	

I confirm the above details are true to the best of by knowledge. I agree to all the rules and regulations of the society and society decision is final.

Date:	Signature of the member
Note: Please attach any important ph	noto /Information which you would like to share voluntarily.
For Office	
Date of Membership Confirmation	:
Amount Paid in Rs.	:
Mode of Payment	:
Receipt no and Date	:
Membership No	:
Member State	:
Member ID	:
Accounts	Treasurer
Please attach a Photo(Other)	

(Note: You can strike out for the pints not willing to provide consent)



<u>ORDI – Patient Consent Form and Non-Disclosure Undertaking Date:</u>

I, BISWAJIT MALLICK	
, son/daughter/wife/father/Mother/Guardian of MAYA MALLICK	
residing at HOWRAH	
And suffering from MUCOPOLYSACCHARIDOSIS DISEASE TYPE-II (MPS-II) Disease, being a member of	of
ORDI bearing Membership No wish to voluntarily participate in all the activities organized by ORDI a	
agree to give my consent for the ORDI activities listed below in the interest of ORDI patients, parents and	1110
caregivers.	
For discussing my disease and case history.	
I hereby authorize ORDI to use my name, patient history, Medical records, treatment that I have	
undergone, history and any useful information in whatever form as may be necessary.	
I do not hold ORDI for any claims/liabilities/obligations relating to privacy/confidentiality with respect	t to
the disclosure of the aforesaid information for the purposes of the ORDI activity.	
I hereby authorize ORDI to use my collected human sample for diagnostic or research purpose in India	or
abroad as deemed necessary by ORDI	
I further authorize the Society to record and use any of the information by way of audio/video recording	g or
any other form in whole or in part, for dissemination of information.	
I also authorize ORDI to use my information, photo, video, Records to press, media or for	
research, publication, raising funds or any other useful purpose.	
I acknowledge that any interaction and discussions with the ORDI society would be for my benefit. It	
would help in understanding in managing and treating my disease / disorders better.	
I agree to any decision taken on my behalf for the betterment of my disorder and lifestyle.	
I also agree to go wherever the society invites me for my betterment.	
I acknowledge and understand that information- other ORDI member information, other patient information and	d
medical details or any other information, that would be disclosed to me as a member of ORDI is confidential.	
I hereby give an undertaking to the ORDI that I shall not disclose the any information to any third party and shall	all
keep the same confidential. The above information has also been explained to me in a language I understand.	
Patient/ Guardian's Name (in case of minors):	

Address:

Contact Details: E mail ID: Signature: