National Healthcare Group POLYCLINICS

CONSENT FOR RELEASE OF MEDICAL INFORMATION

(WITH EFFECT FROM 1 JAN 2023)

Instructions:

1. This form must be duly completed and signed by patient/authorised person. If patient is below 21 years old, the form should be signed by patient's parent or legal guardian. **All names must be in full name as per NRIC/FIN/passport.**
2. If the patient lacks mental capacity or is deceased, consent is required from the authorised representative of the estate by providing applicable legal documents (photocopies of their NRIC/passport, Court Orders and/or Lasting Power of Attorney). Where applicable, the "*Consent for Release of Medical Information by All Children/Siblings*" Form *(WI-OPS-027.F05)* must be provided. If patient is deceased, a copy of patient's death certificate is required.
3. Photocopies of relevant documents (e.g. birth certificate, marriage certificate and letters of administration) are to be attached as proof of relationship to patient if applicable.
4. Patient to enclose a photocopy of own NRIC (front & back view) if submitting via mail or email.
5. The prices stated below include 8% GST. Completed form must be submitted with the appropriate report fee. **Cheque payment should be crossed and made payable to "National Healthcare Group Polyclinics".** Request will be processed upon receipt of completed form and the required supporting documents with full payment of the fee.
6. Kindly note that NHGP is under an obligation to give full and frank disclosure of all material facts relating to your medical condition, including but not limited to, the Human Immunodeficiency Virus (HIV) and any other infectious diseases required to be notified to the Ministry of Health, the Health Science Authority and any other relevant authorities.
7. The release of the medical report is subject to official approval.

Medical Report Ref No: _____
(For Official Use Only)

1. PATIENT'S PARTICULARS

Full Name (As per NRIC / FIN / Passport) _____

***NRIC / FIN No.** _____ Contact No. _____

Residential Address (As per NRIC) _____

2. AUTHORISATION

I, (Full Name as per NRIC/FIN / Passport) _____ *NRIC / FIN No. _____

hereby authorise **NATIONAL HEALTHCARE GROUP POLYCLINICS** to furnish and release the below stated information:

To: Name of Company or Person: _____

Address of Company or Person: _____

(*Note: Report to be furnished only to the above stated Company and/or Person*)

Type of Request:

☐ Medical Report (S$113.40) ☐ Duplicates/Memo with Endorsement (S$5.72) ☐ Others _____

Purpose of Request:

☐ Continuity of Care ☐ Legal Proceedings

☐ Insurance Claims / Application ☐ Others (Please Specify) _____

Specific medical condition to release information for (State N/A if not applicable): _____

Period for which the records will be released from: [START DATE]: _____ **to** [END DATE]: _____

Besides the report fee, I undertake to pay any additional charges such as X-ray and Laboratory Investigation Charges which may be incurred in the preparation of the report. **I am also aware that there will be no refund should I decide to cancel this request**.

3. PREFERRED MODE OF COLLECTION

☐ I will **personally collect** the report once it is ready. Contact No.: _____ I am aware that I will need to provide my NRIC/FIN upon collection and that the report cannot be released if I am unable to do so.

☐ I want my report to be **emailed** to this email address once it is ready. [IN BLOCK LETTERS] _____

☐ Send via **courier** to the address of the company or person as stated in **Part 2: Authorisation**. (An additional fee of S$6.91 for local courier is applicable.)

☐ The report will be collected by my **proxy representative** who is aged 21 and above. I am aware that a duly completed *Letter of Authorisation For Proxy (WI-OPS-027.F04),* copy of patient's NRIC and proxy's physical ID card must be provided upon collection.

I hereby declare and confirm that I have been given adequate explanation on the contents of this form, which has been fully explained to me in _____ (language), and have fully understood the same. The information given above is accurate and true to the best of my knowledge, and that the requisite information is required for the sole purpose stated above. I understand that I may be liable for prosecution for making a false declaration. Further, I confirm that I shall not hold National Healthcare Group Polyclinics or any of its employees, servants or agents responsible in any way whatsoever for the release of the said medical information to any party by me in the event of any loss or damage arising directly or indirectly, as a result or in connection with the release of such confidential information. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite information.

Full Name and Signature of *Patient / Next of Kin / Administrator of Estate	*Self / Relationship to Patient	Date

*** Please delete where applicable**