NHG Polyclinics
NHG Health

LETTER OF AUTHORISATION FOR REFUND COLLECTION

Instructions:

1. This form is to be completed by the patient or the patient's authorised representative in the event that the patient is unable to collect or receive the refund personally and would like to appoint a proxy to collect or receive the payment on their behalf.
2. This form must be duly signed by the patient or the patient's authorised representative. If patient is below 21 years old, the form should be signed by patient's parent or legal guardian.

1. AUTHORISATION TO PROXY

Dear National Healthcare Group Polyclinics ("**NHG Polyclinics**")**,**

I, _____ (*Patient / Authorised Person's Name and NRIC/FIN No),

hereby authorise my _____ (Relationship to *Patient / Authorised Person),

*Mr / Ms _____ (Proxy's Name and NRIC/FIN No.),

to collect or receive a refund of my/the patient's deposit or payment from NHG Polyclinics on my behalf.

2. CONSENT

I hereby consent to the disclosure of my information, including without limitation my and/or the patient's personal data, to the above-named proxy or any third party as deemed necessary by you for the purpose of processing the refund.

I undertake and confirm that I have obtained the necessary consent from the above-named proxy to furnish you with the information contained in this form for the purpose of processing the refund.

I understand that I may withdraw the consent given herein at any time by contacting our Contact Centre at +65 6335 3000 or by writing in to the polyclinic, but that NHG Polyclinics will not be able to process the refund in the event that consent is withdrawn.

3. DECLARATION

I hereby declare and confirm that the information I have given in this form is accurate and true to the best of my knowledge. I acknowledge and agree that NHG Polyclinics (including any of its employees, servants or agents) shall not be held liable or responsible in any way whatsoever for any loss or damage which may arise in connection with the processing of the refund based on the information provided herein or in any other documentation submitted by my duly-authorised proxy, or in connection with the disclosure of my and/or the patient's personal data to any party in accordance with the purposes set out herein.

Signature of Patient / Authorised Person	Date

*Please delete where applicable