CONSENT FOR RELEASE OF MEDICAL INFORMATION BY ALL SPOUSE / CHILDREN / PARENT / SIBLINGS (FOR PATIENT WHO IS UNABLE TO GIVE CONSENT / DECEASED PATIENT)

Instructions:

1. This form is applicable in either of the following cases:
   a. Patient lacks mental capacity, and there is no donee appointed by the Patient under a Lasting Power of Attorney or court-appointed deputy for the Patient; or
   b. Patient is deceased and there is no appointed executor or administrator of the Patient's estate
2. In such cases, the applicant who is applying for the release of the Patient's medical information must be an immediate NOK of the Patient based on the order of priority set out below. If there is an immediate NOK with higher priority, then that NOK must be the applicant (e.g. spouse must be the applicant if Patient has a spouse, children, parents and siblings).:
   a. First priority: Spouse
   b. Second priority: Children
   c. Third priority: Parents
   d. Fourth priority: Siblings
3. The immediate NOK, who is the applicant, must complete and execute both Sections 1 and 2 of this consent form.
4. All other immediate NOKs (i.e. spouse, children, parents and siblings) who are alive, must consent to the application by completing and executing Section 1 of this consent form, regardless of the identity of the applicant.
5. This form serves as consent to release the Patient's medical information.
6. Supporting documents (e.g. marriage certificates, birth certificates) are to be attached as proof of relationship to the Patient.

1. DECLARATION FROM ALL SPOUSE / CHILDREN / PARENT / SIBLINGS OF THE PATIENT

We, *the spouse / children / parent / siblings of (Patient's Name as per NRIC/FIN): _____ of *NRIC No./FIN _____ ("Patient") hereby authorise NATIONAL HEALTHCARE GROUP POLYCLINICS to furnish and release the medical information of the above-mentioned Patient in accordance with the request of the representative mentioned in Section 2. We declare that we are not aware of any donee of the Patient under a Lasting Power of Attorney or any court-appointed deputy for the Patient (where Patient is unable to give consent), or any appointed executor or administrator of the Patient's estate (where the Patient is deceased). By reason of the aforesaid, we undertake full responsibility and liability arising from the release of the medical information and confirm that we shall not hold National Healthcare Group Polyclinics or any of its employees, servants, or agents responsible in any way whatsoever for any loss or damage arising directly or indirectly, as a result or in connection with such release of the medical information.

_____

Signature of Patient's Next-of-Kin

Name (as per NRIC/FIN): _____

*NRIC No./FIN: _____

Relationship: _____

Date: _____

_____

Signature of Patient's Next-of-Kin

Name (as per NRIC/FIN): _____

*NRIC No./FIN: _____

Relationship: _____

Date: _____

_____

Signature of Patient's Next-of-Kin

Name (as per NRIC/FIN): _____

*NRIC No./FIN: _____

Relationship: _____

Date: _____

_____

Signature of Patient's Next-of-Kin

Name (as per NRIC/FIN): _____

*NRIC No./FIN: _____

Relationship: _____

Date: _____

*Delete where applicable.

____________________________	____________________________
Signature of Patient's Next-of-Kin	**Signature of Patient's Next-of-Kin**
Name (as per NRIC/FIN): ________________________	Name (as per NRIC/FIN): ________________________
*NRIC No./FIN: ________________________________	*NRIC No./FIN: ________________________________
Relationship: __________________________________	Relationship: __________________________________
Date: ____	Date: ____
____________________________	____________________________
Signature of Patient's Next-of-Kin	**Signature of Patient's Next-of-Kin**
Name (as per NRIC/FIN): ________________________	Name (as per NRIC/FIN): ________________________
*NRIC No./FIN: ________________________________	*NRIC No./FIN: ________________________________
Relationship: __________________________________	Relationship: __________________________________
Date: ____	Date: ____
____________________________	____________________________
Signature of Patient's Next-of-Kin	**Signature of Patient's Next-of-Kin**
Name (as per NRIC/FIN): ________________________	Name (as per NRIC/FIN): ________________________
*NRIC No./FIN: ________________________________	*NRIC No./FIN: ________________________________
Relationship: __________________________________	Relationship: __________________________________
Date: ____	Date: ____
____________________________	____________________________
Signature of Patient's Next-of-Kin	**Signature of Patient's Next-of-Kin**
Name (as per NRIC/FIN): ________________________	Name (as per NRIC/FIN): ________________________
*NRIC No./FIN: ________________________________	*NRIC No./FIN: ________________________________
Relationship: __________________________________	Relationship: __________________________________
Date: ____	Date: ____

2. REPRESENTATIVE OF ALL SPOUSE / CHILDREN / PARENT / SIBLINGS

I, ____ of *NRIC No./FIN ____________________ am appointed by the above-mentioned *spouse / children / parent / siblings of (Patient's Name as per NRIC/FIN): _________________________________ of *NRIC No./FIN: __________________________ as the representative to apply for the release of the medical information of the patient. I hereby declare that the above contents are true to the best of my knowledge, information and belief. I understand that legal action may be taken against me for any false statement(s) made. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of such medical information of the Patient as requested.

____	______________________________
Signature of Appointed Representative	Date

*Delete where applicable.