LETTER OF AUTHORISATION / UNDERTAKING FOR RELEASE OF MEDICAL/DENTAL INFORMATION

Instructions:

1. This form is applicable where a patient ("**Patient**") wishes to authorise a third party ("**Authorised Person**") to apply on the Patient's behalf for the release of the Patient's medical/dental information.
2. This form is only applicable to Patients who do not lack mental capacity and are at least 21 years old.
3. This form must be duly completed and signed by the Patient. **All names must be in full name as per NRIC/FIN.**
4. The completed and signed form is to be submitted by the Authorised Person as a supporting document when applying on the Patient's behalf for the release of the Patient's medical/dental information.
5. For all medical report requests, a copy of Patient's NRIC and Applicant's NRIC (if applicant is not Patient) with both front and back view should be provided as supporting documents.
6. Kindly note that National Healthcare Group Polyclinics 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 and any other infectious diseases required to be notified to the Ministry of Health, the Health Sciences Authority and any other relevant authorities.
7. The release of the medical report is subject to official approval.

1. AUTHORISATION

I, _____(Patient's Full Name as per NRIC/FIN), _____(Patient's *NRIC No./FIN), hereby authorise:

(a) _____(Authorised Person's Full Name as per NRIC/FIN), _____(Authorised Person's *NRIC No./FIN), who is my _____(Relationship to Patient), to apply on my behalf for the release of my medical/dental information from NATIONAL HEALTHCARE GROUP POLYCLINICS; and

(b) **NATIONAL HEALTHCARE GROUP POLYCLINICS** to furnish and release my medical/dental information as stated below to the Company or Person stated in **Part 2 (Report Information)**.

2. REPORT INFORMATION

Type of Request:

☐ Medical/Dental Report (S$[124.81] (GST incl.)) ☐ Duplicates/Memo with Endorsement (S$[6.32] (GST incl.)) ☐ Others _____

(Note: For eligible subsidised Singapore Citizens and Permanent Residents, GST is absorbed by the Government.)

Purpose of Request: ☐ Continuity of Care ☐ Legal Proceedings ☐ Insurance Claims / Application ☐ Others (Please specify): _____

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

Name of Company/Person _____

Address of Company/Person _____

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)*

*Delete where applicable.

3. CONSENT

I hereby consent to the collection, use and disclosure of my information and personal data (as defined under the Personal Data Protection Act 2012 of Singapore) as deemed necessary by you for the purpose of processing the request for the medical information.

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

I understand that I may withdraw the consent given herein at any time via for.sg/nhgp-enquiries, but in such an event, National Healthcare Group Polyclinics will not be able to process the request for the medical information in the event that consent is withdrawn.

4. DECLARATION

Besides the report fee stated above, I understand that I may be required to pay additional charges such as X-ray and Laboratory Investigation Charges which may be incurred in the preparation of the report. I authorise the above-named Company or Person / the Authorised Person to make payment on my behalf, and in the event, payment is not made by the above-named Company or Person / the Authorised Person, I undertake to make such payment to National Healthcare Group Polyclinics.

I am aware that there will be no refund should the request be cancelled.

The information given above (including information in the supporting documents I have submitted, if any) is accurate and true to the best of my knowledge, and the requested medical 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 or the Authorised Person in the event of any loss or damage arising directly or indirectly, as a result of 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	Date

*Delete where applicable.