



CONSENT FOR RELEASE OF MEDICAL INFORMATION (MEDICAL REPORT)

Notes:

1. This form must be fully completed and signed by the patient, unless: (a) if the patient is below 21 years old, in which case the form should be signed by the patient's parent / guardian; or (b) if the patient is deceased or unable to give consent, in which case consent is required from the appointed representative of the estate. A copy of the patient's death certificate is required if patient passed away outside Ren Ci Hospital.
2. If this form is completed by a proxy, photocopies of relevant documents (e.g. birth certificate, marriage certificate and letters of administration) are to be attached as proof of relationship to patient.
3. A photocopy of the patient's NRIC (both front & back) must be enclosed if submitting via mail or fax.
4. Only completed form will be processed. You will be contacted for payment which can be made via cash, credit card, NETS or cheque.
5. The release of the medical report is subject to official approval and the time frame for completion of medical reports is within 15 working days upon receipt of payment.

PATIENT'S PARTICULARS

Given Name (As in *NRIC/Passport):	
NRIC No.:	
Mailing Address:	
Period of Attendance / Admission in Ren Ci Hospital:	Ward:

REQUEST / AUTHORISATION

I, _____ of NRIC No. _____

hereby authorize Ren Ci Hospital to furnish medical report for the purpose as stated below to:

Myself My Dependent / Representative (Specify relationship: _____) with details as stated:

Name of Company or Person: _____

Mailing Address of Company or Person: _____

Contact No. of Company or Person: _____

For the purpose of:

- Continuity of Care Legal Proceedings Police Investigation
 Insurance Claims Employment Purpose Others (please specify): _____

Any Additional Information: _____

I / The representative am/is aware that fee is payable for the request of medical report. I / The representative will be contacted on the amount to pay and payment is non-refundable should cancellation of this request is decided after payment is made.

PREFERRED MODE OF COLLECTION / DECLARATION

- I will personally collect the report once it is ready. Please contact me at the given contact number.
 Send to the mailing address as stated above (A fee of \$2.50 for local registered mail is applicable).
 The report will be collected by my representative. I am aware that an authorization letter with the representative's name & NRIC No and a copy of my NRIC has to be furnished upon collection.

I hereby declare and confirm that the information given above is accurate and true to the best of my knowledge and belief, and that the requisite information / Medical Report is required for the 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 the Hospital or any of its employees, servants or agents responsible in any way whatsoever for the release of the said information / Medical Report to any party by me in the event of any loses or damage arising directly or indirectly, as a result or in connection with the release of such confidentiality information / Medical Report. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite Information / Medical Report.

Signature of *Patient/ Next of Kin/ Administrator of Estate	Relationship:
	Date:

* Delete where applicable

