CONSENT FOR RELEASE OF MEDICAL INFORMATION (REPORT / RECORD)

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/incompetent to give consent, consent is required from the appointed personal representative/Deputy/Donee of Estate, or if there is no appointed representative, a 'Letter of Undertaking' has to be completed by all family members of the patient. The personal representative/Deputy/Donee shall provide photocopies of their NRIC or passport, Court Orders, Letters of Administration, Lasting Power of Attorney or any legal documents. A copy of the patient's death certificate is required if patient passed away outside Ren Ci Hospital.
2. Photocopies of relevant documents (e.g. birth certificate, marriage certificate or any other documents) are to be attached as proof of relationship to patient if applicable.
3. For request of medical report, 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. If payment is required, you will be contacted for payment which can be made via cash, credit card, NETS or cheque.
5. The release of the medical information is subject to official approval. The time frame for completion of medical report is within 15 working days upon receipt of payment. The provision of the copy of medical records is within 2 working days from the time of request and upon payment where relevant.

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 release the medical *report / record for the purpose as stated below & to (if applicable):

Name of Company / Person: _____

Mailing Address of Company / Person: _____

Contact No. of Company / Person: _____

For the purpose of:

☐ Continuity of Care ☐ Legal Proceedings ☐ Police Investigation

☐ Insurance Claims ☐ Employment Purpose ☐ Others (please specify): _____

Please select where relevant: Copy of Discharge Summary ☐ ; Copy of Investigation/X-Ray Report $5 ☐ ; Others, please specify:_____

I / The representative am/is aware that fee is payable for the request of medical information. 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 medical report/record 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 medical report/record 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 of, or in connection with the release of such confidential information / Medical Report. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite Information / Medical Report.

_____	Relationship:
Signature of *Patient / Personal Representative/ Deputy/Donee of Estate	Date:

** Delete where applicable*

Ren Ci Hospital, Level 2, Business Office, 71 Irrawaddy Road, Singapore 329562
Telephone:6358 0777 Fax: 6355 6405 www.renci.org.sg

COMPLETION - FOR ADMINISTRATION BY BUSINESS OFFICE	☐ CH ☐ NH ☐ LTC
☐ **Collection of Medical Report/Record from Ren Ci Hospital, Business Office**	
Collected by Patient/Representative: _____ **Name / Signature / Date**	**Verified by BO:** _____ **Name / Signature / Date**
☐ **Medical Report Sent via Registered Mail by BO**	
Sent as verified BO staff: _____ **Name / Signature / Date**	