



MEDICAL REPORTS UNIT
DEPARTMENT OF DOCUMENT MANAGEMENT SERVICES
100 BUKIT TIMAH ROAD
SINGAPORE 229899
TEL: (65) 63941209 FAX: (65) 63941295

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Conditions / Instructions

- 1 This form must be fully completed and signed by the patient. If the patient is below 21 years old, the form should be signed by the patient's parent or legal guardian.
- 2 If the patient is deceased, please attach a copy of the death certificate and other documents (eg marriage certificate, birth certificate, letters of administration), whichever is applicable as proof of your relationship to the deceased.
- 3 The patient has to enclose a photocopy of own NRIC (front & back view) or passport or Birth Certificate if submitting via mail and fax.
- 4 The completed form must be submitted with the appropriate fee.
For payment by cheque, it should be crossed and made payable to "KK Women's and Children's Hospital Pte Ltd".
- 5 The release of the medical information is subject to official approval.

PARTICULARS OF PATIENT

Name (As in *NRIC/Birth Certificate/Passport): _____

NRIC / BC / Hospital Registration No: _____ Contact No: _____

Mailing Address: _____ Postal Code: _____

Period Of Attendance/Admission in KKH: _____ Clinical Department: _____

DECLARATION

I, _____ NRIC No _____
hereby authorise **KK WOMEN'S & CHILDREN'S HOSPITAL** to furnish and release the chosen report below:-

- | | |
|---|---|
| <input type="checkbox"/> Ordinary Medical Report [MRORD] (\$80.25) | <input type="checkbox"/> Laboratory Results (\$5.35) (please specify date) _____ |
| <input type="checkbox"/> Specialist Medical Report [MRSPE] (\$160.50) | <input type="checkbox"/> Investigation Reports (\$5.35) (please specify date) _____ |
| <input type="checkbox"/> Second Opinion Medical Report (\$374.50) | <input type="checkbox"/> Notification of Live-Birth / Sexual Sterilisation (Ligation) Certificate* (\$5.35) |
| <input type="checkbox"/> Simple Insurance Form (by DDMS staff) (\$21.40) | <input type="checkbox"/> Medical Certificate (\$10.70) |
| <input type="checkbox"/> Others (please specify) _____ | |

On: Myself My Dependent (Please specify relationship) _____

To: Name Of Company Or Person _____

Address Of Company Or Person _____

For the purpose of:

- Continuity of Care Insurance – Life Assurance / Claims Legal Proceedings (Please specify) _____
- Others (Please specify) _____

Besides the medical report fee, I undertake to pay any additional charges such as x-ray and laboratory investigation charges which may be incurred in the preparation of the report. I am also aware that there will be a cancellation charge of 1/3 of the medical report fee, should I decide to cancel this request.

PREFERRED DELIVERY

I will personally collect the report once it is ready. Please contact me at _____.

Send to my mailing address as stated above by ordinary/registered mail*. (A fee of \$2.50 for registered mail is applicable)

I hereby declare and confirm that the information given above is accurate and true to the best of my knowledge, and that the requisite 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 the Hospital or any of its employees, servants or agents responsible in any way whatsoever for the release of the said information to any party by me 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.

Signature of Patient / Patient's Parent / Next of Kin*

Date

FOR OFFICIAL USE

Received by (Staff Name): _____ Signature of Staff: _____ Date: _____

MR Number: _____ Receipt No: MRP _____ (*Cash / Nets / Visa / Cheque)