Reg No 198904227G

KK Women's and Children's Hospital
SingHealth

HEALTH INFORMATION MANAGEMENT SERVICES
MEDICAL REPORTS UNIT
100 BUKIT TIMAH ROAD SINGAPORE 229899
TEL: (65) 63941209 (Mon-Fri 8.30am to 5pm)

CONSENT FOR RELEASE OF MEDICAL INFORMATION

1 Identification Documents required

a) Patient 21 years and above	▪ Patient's NRIC (front & reverse) ▪ Valid passport or identification document issued by Singapore authorities (for non-residents)
b) Patient below 21 years old	▪ Patient's Birth Certificate ▪ 1 Parent's NRIC (front & reverse) ▪ Valid passport or identification document issued by Singapore authorities (for non-residents)
c) Other supporting documents if applicable (insurance form, court documents etc)	

2. All the fields in the consent form are mandatory and to sign by the patient OR parent/ legal guardian for patients below 21 years old.
3. Incomplete form and non-payment will result in processing delays.
4. Release of medical information is subject to final approval by the Hospital.
5. Please email to "Insurance.GenEnquiry@kkh.com.sg" upon completion of this consent form together with the identification documents &/ or others supporting documents.

Patient Particulars

Name (As in NRIC/ Birth Certificate): ______________________ NRIC/ BC/ Hospital Registration No: ______________

Visit/ Admission in KKH (DDMMYYYY): ______________________ (Eg. Admission Date, Outpatient Visit, Day Surgery,etc.)

Clinical Department/ Specialty: ______________________ (Eg. Ward, Clinic Name, Doctor's Name, Medical Condition, etc.)

Patient Authorisation

I, ______________________ NRIC No: ______________ hereby authorize **KK WOMEN'S & CHILDREN'S HOSPITAL Pte Ltd** to furnish and release the requested medical information and/or report(s).

Patient is: ☐ Myself ☐ My Child

Name: ______________________

*Mailing Address: ______________________ Postal Code: __________

Mobile No: ______________ Payment instruction will be sent via SMS within 3 working days from date of receipt of application.

Email Address: ______________________

***Completed Medical Report will be sent to the Mailing Address by Registered Post.**

Please tick the report(s) requested:

☐ Ordinary Medical Report (S$141.70) (Completion of Insurance Form)
☐ Specialist Medical Report (S$294.30) (include prognosis)
☐ Laboratory Results/ Investigation Reports (S$12.00 per report)
☐ Day Surgery Authorisation Form (S$12.00)
☐ Inpatient Discharge Summary (S$12.00)
☐ Referral Letter (S$12.00)
☐ Ordinary Medical Report (Psychiatric) (S$264.90)
☐ Specialist Medical Report (Psychiatric) (S$489.00)
Others (Please specify): ______________

Please tick the purpose(s) of the requested report(s)
☐ Continuity of Care ☐ Insurance ☐ Second Opinion ☐ Legal Proceedings ☐ Others (Pease specify): ______________

I undertake to pay the specified charges for the application of medical information. Should I cancel the application once it has been processed, there will be no refund of payment.

Rates are in SGD and apply to Singapore Citizens and Permanent Residents only.

Rates are correct at point of printing and subject to changes without prior notice.

I declare the information given above is accurate and true to the best of my knowledge. I understand that I may be liable for prosecution for making a false declaration.

______________________ Signature of Patient/ Parent (if patient is below 21 years old)

______________ Date

FOR OFFICIAL USE Received By (Staff Name/ Signature): ______________________ Date: ______________

MR Reference No: ______________________