Tan Tock Seng HOSPITAL

Health Information Services (MRO)
Tan Tock Seng Hospital Podium Block
Level 2, 11 Jalan Tan Tock Seng
Singapore 308433
Tel: 6357 8448 Fax: 6357 8449

CONSENT FOR RELEASE OF MEDICAL INFORMATION (MEDICAL REPORT)

Notes:

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.
2. If the patient is deceased or unable to give consent, consent is required from the appointed representative of the estate. Where applicable, the "Consent for release of medical information by all children / siblings" form must be filled up. A copy of patient's death certificate is required if patient passed away outside TTSH.
3. Photocopies of relevant documents (e.g. birth certificate, marriage certificate and letters of administration) are to be attached as proof of relationship to patient if applicable.
4. Patient has to enclose a photocopy of own NRIC (front & back view) if submitting via mail and fax.
5. Completed form must be submitted with appropriate fee.
6. The release of the medical information is subject to official approval.

PATIENT'S PARTICULARS

Given Name (As in *NRIC/Passport): ______________________________

NRIC No : ______________________________

Mailing Address: ______________________________

Period of Attendance / Admission in TTSH: ______________________ Clinical Department: ______________________

REQUEST

I, ______________________________ of NRIC No ______________________________

hereby authorize TAN TOCK SENG HOSPITAL to furnish and release below stated

TO: Name of Company or Person: ______________________________

Address of Company or Person: ______________________________

Type of Request: ☐ Ordinary Medical Report (S$80.25) ☐ Specialist Medical Report (S$160.50)

☐ Second Opinion Report ☐ Others (Please Specify): ____________________

Purpose: ☐ Continuity of Care ☐ Legal Proceedings ☐ Second Opinion

☐ Insurance Claims ☐ Others (Please specify): ______________________________

Remarks: ______________________________

Besides the medical report fee, I undertake to pay any additional charges such as x-ray and laboratory investigation charges that 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 MODE OF COLLECTION

☐ I will personally collect the report once it is ready. Contact No: ______________________________

☐ Send to my mailing address as stated above. (A fee of $10 for overseas postage is applicable)

☐ Send to the address of the company or person as stated above. (A fee of $10 for overseas postage 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 Record 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 Record to any party by me in the event of any loss or damage arising directly or indirectly, as a result or in connection with the release of such confidentiality information / Medical Record.
By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite Information / Medical Record.

Relationship: ______________________________

____
Signature of *Patient / Next of Kin / Administrator of Estate

Date: ______________________________

* Delete where appropriate