Tan Tock Seng HOSPITAL

Health Information Services (MRO)
Tan Tock Seng Hospital Atrium Block
Level 2, 11 Jalan Tan Tock Seng
Singapore 308433
Tel: 6357 8448 Fax: 6357 8449
Email: hisadmin@ttsh.com.sg

CONSENT FOR RELEASE OF MEDICAL INFORMATION

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.
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, fax or email.
5. The completed form must be submitted with payment of the fee. Cheque payment should be crossed and made payable to "Tan Tock Seng Hospital Pte Ltd".
6. The release of the medical information is subject to official approval.
7. Kindly note that TTSH is under an obligation to give full and frank disclosure of all material facts relating to your medical condition, including but not limited to, the Human Immunodeficiency virus (HIV) and any other infectious diseases required to be notified to the Ministry of Health, the Health Sciences Authority and any other relevant authorities.

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$90.00)
- ☐ Specialist Medical Report (S$180.00)
- ☐ Workman Compensation Initial Report (S$90.00)
- ☐ LPA Lasting Power Of Attorney Assessment (S$225.00)
- ☐ PSY Simple Factual Report (S$225.00)
- ☐ PSY Complex Report Mental Capacity/CAD (S$480.00)
- ☐ Second Opinion Report (S$300.00)
- ☐ Medical Certificate/Medical Report CTC (S$12.00/Copy)
- ☐ Lab Test/ X-Ray Report (S$6.00/Type)
- ☐ MMG + US (S$48.00)
- ☐ Discharge Summary (No Charges)
- ☐ Others (Please specify): _____

Purpose of Request:

- ☐ Continuity of Care
- ☐ Insurance Claims
- ☐ Insurance Application
- ☐ Legal Proceedings
- ☐ Second Opinion
- ☐ Others (Please specify): _____

Remarks: _____

Besides the medical report fee, I undertake to pay any additional charges such as the administrative fee, X-ray and laboratory investigation charges that may be incurred in the preparation of the report.

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 S$10 for overseas postage is applicable)
- ☐ Send to the address of the company or person as stated above. (A fee of S$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 have to be furnished upon collection.

I hereby declare and confirm that I have been given adequate explanation on the contents of this form, which has been fully explained to me in _____ (language), and have fully understood the same. 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 Tan Tock Seng Hospital or any of its employees, servants or agents responsible in any way whatsoever for the release of the said medical information 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 confidential information. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite information.

_____	_____	_____
Signature of *Patient / Next of Kin / Administrator of Estate	Self / Relationship to Patient	Date

* Delete where appropriate