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

CONSENT FOR RELEASE OF MEDICAL INFORMATION (Form A)

Instructions:

1. This form must be fully completed and signed by the patient.
   If the patient is below 21 years old, the form must be signed by the patient's parent or guardian.
2. If the patient is mentally incapacitated or deceased, this form must be submitted together with Form B.
3. For application via mail or email, a copy of patient's identification document (front & back view) is required.
4. The release of the medical information is subject to official approval.
5. Request will be process upon receipt of completed form(s) and the required supporting document(s) with full payment of the fee.
6. 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.: ______________________ Contact No.: ______________________

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

PURPOSE AND TYPE OF REQUEST *(Please tick accordingly)*

Purpose of Request:

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

Type of Request[1]:

	Ordinary Medical Report (S$101.80)		Memo (S$6.20/Copy)
	Specialist Medical Report (S$183.40)		Medical Certificate/Medical Report CTC (S$10.20/Copy)
	Workman Compensation Initial Report (S$101.80)		Lab Test/ X-Ray/ Histology Report (S$10.20/Type)
	LPA Lasting Power Of Attorney Assessment (S$229.20)		Mammogram + Ultrasound Report (S$49.00)
	Psychiatric Specialist Medical Report (Simple) (S$229.20)		Discharge Summary (No Charges)
	Psychiatric Specialist Medical Report (Complex) Mental Capacity / Court Appointed Deputy (S$509.30)		Others (Please specify):
	Second Opinion Report (S$356.60)		

Remarks: ______________________

Credit card details

Card number: ______________________ Expiry date (MM/YY): ______________________

[1]***Note: Prices are inclusive of a non-refundable administrative charge***
(S$15 for Brief Medical report, S$30 for Ordinary Medical Report and S$50 for all other reports)

PREFERRED MODE OF DELIVERY *(Please tick 1 option only)*

☐ Email the report to (Email address): ______________________

☐ Local Ordinary Mail ☐ Local / Overseas Registered Mail (Postage fee of S$10.20 is applicable)

Recipient / Company Name: ______________________

Mailing Address: ______________________

☐ Self-collect / Collected by my representative. I am aware that a letter of authorization (Form C) with the representative's name & NRIC No. and a copy of my NRIC must be furnished during collection.

AUTHORIZATION

I (requestor), ______________________ NRIC No.: ______________________

hereby authorize TAN TOCK SENG HOSPITAL to furnish and release the above stated.

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 and I 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