CONSENT FOR RELEASE OF PATIENT'S MEDICAL REPORTS AND 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/guardian.
2. If the patient is deceased/mentally incompetent, consent is required from the patient's authorised representative(s). Authorised representative(s) are to provide photocopies of their NRIC or Passport, Court Orders, Lasting Power of Attorney and/or other legal documents (where applicable). A copy of the patient's death certificate is required (where applicable). If an authorised representative has not been appointed, a separate Letter of Undertaking has to be completed by all family members of the patient.
3. Photocopies of relevant documents (e.g. birth certificate, marriage certificate, death certificate and letters of administration) are to be attached as proof of relationship to the patient (where applicable).
4. The patient has to enclose a photocopy of his/her own NRIC (front & back view), Passport or Birth Certificate if the patient is submitting this request via mail, fax and/or email.
5. Alexandra Hospital (AH) reserves the right to refuse a request for release of the patient's medical report(s) and/ or medical information if AH if of the view that such person(s) may not have the necessary authority to make the request.
6. The release of any medical report(s) and/ or medical information of the patient is always subject to the final decision and approval of AH.

PATIENT'S PARTICULARS

Name : _____

NRIC / HRN : _____ Contact No: _____

Address : _____

Date of Hospital Attendance: _____ Clinical Department: _____

REQUEST FOR MEDICAL REPORT(S) AND/OR MEDICAL INFORMATION

I, _____ of NRIC No _____
hereby authorize ALEXANDRA HOSPITAL to furnish and release the abovementioned patient's medical report(s) and/or medical information of the type(s) stated below

TO: Name of Company or Person: _____

Address of Company or Person: _____

Type of Request:

☐ Ordinary Medical Report ($80.25)
☐ Specialist Medical Report ($180.20)
☐ Detailed Insurance Form ($80.25)
☐ Lasting Power of Attorney Assessment ($225.00)
☐ Psychiatric Mental Capacity Report ($480.00)
☐ Diagnosis/ Procedure ($21.40)
☐ Copy of Medical Certificate / Day Surgery Report / Lab Results/ X-ray ($10.70) _____
☐ Others (please specify) _____

Purpose of Request:

☐ Third Party Claim
☐ Continuity of Care
☐ Insurance Claims
☐ Insurance Application
☐ Second Opinion
☐ Legal Proceedings (please specify) _____
☐ Personal (New employment)
☐ Others (please specify) _____

Besides the fee for the medical report(s) and/or medical information, I undertake to pay all additional associated charges such as x-ray and laboratory investigation charges that may be incurred during AH's preparation of the patient's medical report(s) and/or medical information.

PREFERRED MODE OF DELIVERY

☐ I will personally collect the medical report(s) and/or medical information once it is ready. **I am aware that I will need to furnish my NRIC/Passport to AH upon collection and that the medical report(s) and/or medical information cannot be released to me if I am unable to do so.** My contact number is _____.

☐ The medical report(s) and/or medical information will be collected by my representative**. I am aware that an authorisation letter with the representative's name and NRIC/Passport number and a copy of my NRIC/Passport has to be furnished to AH upon collection and that the medical report(s) and/or medical information cannot be released if my representative is unable to do so.**

☐ Send to the address as indicated by Normal / Registered Mail* (*Please delete accordingly*)

☐ Send to the address of the company or person as indicated by Normal / Registered Mail* (*Please delete accordingly*)

☐ Email to this email account: _____ .

I hereby declare and confirm that I am competent to give the above consent and 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 to prosecution under the law for making any false declaration herein. Further, I confirm that I shall not hold Alexandra Hospital or any of its employees, servants or agents responsible or liable in any way whatsoever for the release of the said medical report(s) and/or medical information to any party by me in the event of any claims, losses, damage or costs arising directly or indirectly as a result of, or in connection with the release of such confidential medical report(s)/information. By reason of the aforesaid, I undertake full responsibility and liability and shall fully indemnify Alexandra hospital, its employees, servants and agents against all claims, losses, damages and costs in connection with the release of the said medical report(s) and/or medical information of the abovementioned patient.

I further acknowledge and agree that if I provide an overseas postal address or if I open the email overseas, the overseas country may not have any data protection laws or have data protection laws which are dissimilar to Singapore's Personal Data Protection Act 2012, and I do so at my own risks.

_____	_____	_____
Signature of Patient & Date	Signature of Parent / Next of Kin / Administrator of Estate / Donee/ Deputy* & Date ***(Refer to Instructions 1 & 2)***	Relationship to Patient