Polyclinics
SingHealth

CONSENT / LETTER OF UNDERTAKING FROM PATIENT'S NEXT-OF-KIN

Instructions:

1. This form must be duly 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 / incompetent, consent is required from the appointed Administrator of Estate. If an Administrator of Estate 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 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) / Birth Certificate 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 : _____

Address : _____

_____

Date of Clinic Attendance : _____ Polyclinic: _____
(For which this application for medical Information is to cover)

DECLARATION

I, _____ NRIC No _____
hereby authorise SingHealth Polyclinics to furnish and release the chosen report below

☐ Re-print of Lab report/ X-ray report/ Memo/ Medical Report /External prescription (Delete where applicable)
☐ Medical / Dental Report ☐ Memo with Endorsement
☐ Others (Pls specify) _____

ON ☐ Myself ☐ My Dependent (Pls specify Relationship) _____

TO Name of Company or Person _____

Address of Company or Person _____

FOR THE PURPOSE OF :

☐ Continuation of care ☐ Insurance Claims
☐ Application of Administrator of Estate ☐ Insurance Proposal
☐ Others (Please specify) : _____

Besides the medical report fee, I undertake to pay any additional charges such as x-ray or laboratory investigation charges which may be incurred in the preparation of the report. Cheque should be made payable to "SingHealth Polyclinics". Kindly indicate your name, NRIC and contact number on the back.

PREFERRED MODE OF DELIVERY

☐ I will personally collect the report at the Polyclinic.
☐ Courier to the address of the company or person as stated above.
☐ Courier to my home address

Please contact me at Tel: _____ Please email me at Email: _____

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 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 Polyclinic or any of its employees, servants or agents responsible in anyway whatsoever for the release of the said 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 confidentiality information. By reason of the a foresaid, I undertake full responsibility and liability arising from the release of the requisite information.

* Delete where appropriate

Signature of Patient / Parent / Next of Kin (specify relationship: _____) Date _____