

- Admiralty Medical Centre
- Khoo Teck Puat Hospital
- Yishun Community Hospital

APPLICATION & CONSENT FOR RELEASE OF MEDICAL INFORMATION – FORM A

In accordance with the Personal Data Protection Act (PDPA), application can only be made by patient, with the Exception: If the patient is a minor, deceased or mentally incapacitated

The release of the medical information is subjected to official approval. Kindly note that Yishun Health, which comprises of Admiralty Medical Centre, Khoo Teck Puat Hospital and Yishun Community Hospital, is under obligation to give full and frank disclosure of all facts relating to your medical conditions, including but not limited to 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 and any past medical history.

PATIENT'S PARTICULARS

Name: _____ NRIC/HRN: _____
 Email: _____ Contact No. _____
 Clinic Visit Date: _____ Speciality : _____
 Or Admission Period

PURPOSE OF REQUEST

- Insurance Claim Insurance Application Legal Proceedings Continuity Care Second opinion Personal

Select	Report Type	Fees\$ (GST Incl)	Service Code
	Mental Capacity Act Medical Report *	430.00	MN0223
	CPF – Medical Certification *	90.00	MN0224
	Disability & Mobility Report – Car-park Label for the Handicapped*	21.40	MN0228
	LPA (Lasting Power of Attorney) Form *	200.00	MN0225
	Functional Assessment Report *	37.45	MN0212
	Therapy Report	90.00	MN0226
	Insurance Form by Doctor (Ordinary)*	90.00	MN0044
	Permanent Disability Claim Form*	180.00	MN0222
	Ordinary Medical Report	90.00	MN0045
	Specialist Medical Report	180.00	MN0046
	Pre-Work Injury Compensation Medical Report*	90.00	MN0060
	Work Injury Compensation Initial Assessment Report*	90.00	MN0047
	Work Injury Compensation Reassessment Report *	90.00	MN0056
	Work Injury Compensation Medical Board Report*	357.00	MN0048
	Second Opinion Report	300.00	MN0049
	<u>Reports by Psychiatrist (Type of Report will be advised by Psychiatrist)</u>		
<input type="checkbox"/>	Specialist Medical Report (Simple)	200.00	MN0149
<input type="checkbox"/>	Specialist Medical Report (Complex)	450.00	MN0150
<input type="checkbox"/>	Work Injury Compensation Initial Assessment Report*	200.00	MN0151
<input type="checkbox"/>	Medico-Legal Medical Report (Simple)	600.00	MN0307
<input type="checkbox"/>	Medico-Legal Medical Report (Complex)	1000.00	MN0308
<input type="checkbox"/>	Forensic Report (Simple)	1200.00	MN0152
<input type="checkbox"/>	Forensic Report (Complex)	3000.00	MN0154
	Duplication of Investigation Result	6.00 -per copy	MN0059
	Medical Certificate (Duplicated-Certified True Copy)	12.00-per copy	MN0052
	Digital Medical Certificate	No Charge	-
	<u>Memorandum-Only the following criteria will be accepted.</u>		
<input type="checkbox"/>	(i) Certification of diagnosis.	No Charge	-
<input type="checkbox"/>	(ii) (A)Fit to work (B) Fit to drive(C) Fit for flight travel.		
<input type="checkbox"/>	(iii) Referrals to: (A) KTPH specialities (B) Laboratory/Radiology procedures.		
<input type="checkbox"/>	(iv) Memo for purchasing medical devices.		
<input type="checkbox"/>	(v) Very brief medical condition (eg. BP reading/height/weight).		
	Discharge Summary	No Charge	-

*Relevant form must be provided.

PREFERRED MODE OF DISPATCH (Please Select One Only)

EMAIL: Please specify recipient's email.

Note: A hard copy of the report will not be provided.

OR

COURIER MAIL (\$10.00(GST Incl)-Service Code: MN0135) –WITHIN SINGAPORE ONLY:
Please specify recipient's name, address and contact number for delivery.

No courier service for overseas mail. Only registered mail for overseas postage (\$10.00(GST Incl)-Service Code: MN0135).

CONSENT

I, _____ NRIC/HRN _____ hereby authorise Yishun Health to furnish and release the requested medical information of stated report /reports on Myself (patient) on my Dependent - specify relationship to patient _____.

In addition to the medical report fees, I undertake to pay any additional charges such as consultation/assessment fees, radiological procedures and laboratory investigation charges that may be incurred in the preparation of the medical report.

I hereby declare and confirm that the requisite information is required for the sole purpose as stated. I understand that I may be liable for prosecution for making any false declaration herein. Further, I confirm that I shall not hold Yishun Health or any of its employees, servants, or agents liable 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 of, or in connection with the release of such confidential information. I also confirm that if I request for the report to be posted to me, the address/ particulars I provide to Yishun Health are correct, and that I shall not hold Yishun Health liable if the post should be lost, not delivered by the postal service in a timely fashion or inadvertently opened by another person(s). By reason of the foresaid, I undertake full responsibility and liability for the release of the requisite information.

Patient's/Applicant's Signature

Relationship to Patient (if applicable)

Date: _____

If patient is a minor, deceased or mentally incapacitated, the applicant, spouse/child/parent/sibling/caregiver, has to complete an additional consent form-consent form B. Also, need to attach relevant document copies for verification of relationship with patient. Please refer to Notes on Application for the release of medical information consisting details on consent and application procedure.

FOR OFFICIAL USE

Verified by (Name and Signature of Staff)

Date

KTPH webpage - to apply for a medical report

Healthhub webpage- to apply for a medical report

