Khoo Teck Puat Hospital NHG Health
Yishun Community Hospital NHG Health

ADDITIONAL CONSENT FOR RELEASE OF MEDICAL INFORMATION
(FOR PATIENT WHO IS UNABLE TO GIVE CONSENT / DECEASED) [FORM B]

Notes:
1. Spouse / children / parents / siblings / caregiver of the patient are to complete this form, in addition to Form A.
2. The representative of the patient's parents / children / siblings is to fill up Section B of the form. This serves as consent to release the patient's medical information.
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.

SECTION A: DECLARATION BY THE APPLICANT/ REPRESENTATIVE

I,_____of NRIC No_____am the *spouse / child / parent / sibling / caregiver of (Patient's Name):_____of NRIC NO: _____ and also the representative for the release of the medical information of the patient. I hereby declare that the above contents are true to the best of my knowledge, information and belief. I understand that legal action may be taken against me for any false statement(s) made. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of such medical information of the patient as requested.

_____ _____

Signature of Appointed Representative Date

SECTION B: CONSENT AND DECLARATION BY OTHER LIVING SPOUSE/ CHILDREN/ PARENTS/ SIBLINGS/ CAREGIVER

We, the *spouse / children / parents / siblings / caregiver of (Patient's Name):_____of NRIC No_____hereby authorise Yishun Health (which comprises Admiralty Medical Centre, Khoo Teck Puat Hospital and Yishun Community Hospital), to furnish and release the medical information of the above-mentioned patient. By reason of the aforesaid, we undertake full responsibility and liability arising from the release of the medical information.

_____ _____

Signature of Patient's Next-of-Kin Signature of Patient's Next-of-Kin

Name: _____ Name: _____

NRIC: _____ NRIC: _____

Relationship: _____ Relationship: _____

_____ _____

Signature of Patient's Next-of-Kin Signature of Patient's Next-of-Kin

Name: _____ Name: _____

NRIC: _____ NRIC: _____

Relationship: _____ Relationship: _____

** Delete where appropriate*