Khoo Teck Puat Hospital
National Healthcare Group

Medical Records Office
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Singapore 768828
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Fax: 6602 3786
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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Important 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 patient is deceased/ mentally incompetent, consent is required from the appointed representatives. Appointed representatives are to provide photocopy of their NRIC or passport, Court Orders, Lasting Power of Attorney and/ or other legal documents (where applicable). If there is no appointed representative, the "**Consent for Release of Medical Information by all children / siblings**" form must be filled up. A copy of patient's death certificate is required.
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 to enclose a photocopy of own NRIC (front & back view) 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.
7. Kindly note that Khoo Teck Puat 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.
8. Collection, use and discretion of your personal data are in accordance to our privacy policy, which is available at https://www.ktph.com.sg/pdpa.

Note: For payment by cheque, it should be crossed and made payable 'Alexandra Health Pte. Ltd.' Kindly indicate your name, NRIC / FIN number and contact number at the back of the cheque.

PATIENT'S PARTICULARS (Must complete ALL fields)

Patient's Name: _____ NRIC / HRN: _____

Address: _____ Contact No: _____

_____ Email: _____

Period of Clinic Visits / Admission in KTPH: _____ Medical Specialty: _____

CONSENT (Must complete ALL fields)

I, _____, NRIC No.: _____

hereby give consent to the release of medical information on:

☐ Myself ☐ My Dependent (Please specify Relationship): _____

To: ☐ Refer attached form ☐ Others (please specify):

Name and address of Person or Company: _____

- *Besides the medical report fee, I undertake to pay any additional charges such as x-ray or laboratory investigation charges and assessment fees which may be incurred in the preparation of the report.*
- *I am aware that there will be a cancellation fee of 1/3 of the medical report fee, should I decide to cancel this request.*
- *Cancellation is not allowed if doctor has already prepared the report.*

PREFERRED MODE OF COLLECTION (Please tick as relevant)

❑ I will personally collect the report once it is ready. My Contact no:_____. I am aware that I will need to furnish my NRIC upon collection and that the medical report cannot be released if I am unable to do so.

❑ Courier to my address. A fee of $10.00 is applicable *(MN0135).*

❑ The reports will be collected by my representative. I am aware that an authorisation letter with the representative's name & NRIC No and a copy of my NRIC has to be furnished upon collection.

❑ Courier to the address of the person or company as stated above. A fee of $10.00 is applicable *(MN0135).*

Section A: PURPOSE OF REQUEST (Please tick as relevant)

- ❑ Insurance claim
- ❑ New insurance application
- ❑ Legal proceedings
- ❑ Work injury compensation
- ❑ Continuity of care
- ❑ Second Opinion
- ❑ Others (Please specify): _____

Section B: TYPES OF REPORT (Please tick as relevant)

Report Type

- ❑ 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 Certificate * - *$200.00 (MN0225)*
- ❑ Functional Assessment Report * - *$37.45 (MN0212)*
- ❑ Therapy Report - *$90.00 (MN0226)*

- ❑ Insurance Form by Medical Records Office * - *$20.35 (MN0043*)
- ❑ Insurance Form by Doctor (Ordinary) ***** - *$90.00 (MN0044)*
- ❑ Insurance Form by Doctor (Comprehensive) ***** - *$140.00 (MN0256)*
- ❑ 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)*

Report Type

- ❑ Second Opinion Report - *$300.00 (MN0049)*

Reports by Psychiatrist
(Type of Report will be advised by Psychiatrist)

- ❑ Permanent Disability Claim Form * - *$200.00 (MN0146)*
- ❑ Specialist Medical Report (Simple) - *$200.00 (MN0149)*
- ❑ Specialist Medical Report (Complex) - *$450.00 (MN0150)*
- ❑ Work Injury Compensation Initial Assessment Report * - *$200.00 (MN0151)*
- ❑ Forensic Report (Simple) - *$1,200.00 (MN0152)*
- ❑ Forensic Report (Complex) - *$3,000.00 (MN0154)*

Others

- ❑ Referral Letter *(No charge)*
- ❑ Discharge Summary *(No charge)*
- ❑ Duplication of Investigation Result - *$6.00 per copy (MN0059)*
- ❑ Duplicated Medical Certificate - *$12.00 (MN0052)*

- ❑ Others (please specify): _____

** Requestor to provide forms*

I hereby declare and confirm that I have given adequate explanations on the content of this form and 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 any false declaration herein. Further, I confirm that I shall not hold Khoo Teck Puat hospital 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 Khoo Teck Puat Hospital are correct, and that I shall not hold Khoo Teck Puat Hospital liable if the post should be lost, not delivered by the postal service in a timely fashion or inadvertently opened by other person(s). By reason of the foresaid, I undertake full responsibility and liability from the release of the requisite information.

_____	_____	_____
Signature of Patient/Date	Signature of Parent / Guardian / Next-of-Kin /Administrator of estate/Date	Relationship to Patient

(Refer to the above stated instructions 1 & 2)

For Your Information

- *Ordinary Medical Report – this is a factual report based on available medical information of the patient.*
- *Specialist Medical Report – this is a report which required an opinion with regards to prognosis and disability of the patient.*
- *Second Opinion Report – for non-KTPH patient but who wish to seek an opinion from our specialist. Above fees applied for each form and for each medical specialty.*