CONSENT FOR RELEASE OF MEDICAL INFORMATION – FORM A

Instructions:

1. This form must be fully completed and signed by the patient. If the patient is below 21 years old, the form must be signed by the patient's parent or guardian.
2. If the patient is mentally incapacitated or deceased, applicant will also need to submit with Form B.
3. 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.
4. Please use the official consent forms from Khoo Teck Puat Hospital's website only. Patients can submit the consent form with supporting documents, into our physical drop box outside Patient Service Centre, Tower A Level 1. A copy of patient's identification document (front & back view) is required for mail/email requests. Yishun Health does not engage third party to collect consent forms from the patients.
5. Request will only be processed upon receipt of the completed form, the required supporting documents and full payment of the report fee.

PATIENT'S PARTICULARS

Given Name (As in NRIC/Passport): _____ Contact No. _____

NRIC/HRN: _____ Email: _____

Institution: ☐ Khoo Teck Puat Hospital ☐ Yishun Community Hospital ☐ Admiralty Medical Centre

Ward/Clinic: _____ Visit / Admission Date: _____

PURPOSE OF REQUEST

☐ Insurance Claim ☐ Insurance Application ☐ Legal Proceedings ☐ Continuity of Care ☐ Second opinion ☐ Personal

TYPE OF REQUEST (*please tick accordingly*):

Tick	Report Type	Fees$ (9% GST Incl)	Code
	Ordinary Medical Report	91.68	MN0045
	Insurance Form by Doctor (Ordinary)*	91.68	MN0044
	CPF – Medical Certification*	91.68	MN0224
	LPA (Lasting Power of Attorney) Form*	222.08	MN0225
	Specialist Medical Report	183.36	MN0046
	Mental Capacity Act Medical Report*	477.46	MN0223
	Pre-Work Injury Compensation Medical Report*	91.68	MN0060
	Work Injury Compensation Initial Assessment Report*	91.68	MN0047
	Work Injury Compensation Reassessment Report *	91.68	MN0056
	Work Injury Compensation Medical Board Report*	370.39	MN0048
	Second Opinion Report	305.60	MN0049
	Therapy Report	91.68	MN0226
	Permanent Disability Claim Form*	183.36	MN0222
	Duplication of Investigation Result	6.11 -per copy	MN0059
	Medical Certificate (Duplicated-Certified True Copy)	12.23-per copy	MN0052
	Discharge Summary	No Charge	-
Brief Medical Report			
	Functional Assessment Report*	44.04	MN0212
	Disability & Mobility Report – Car-park Label for the Handicapped*		
	Specialist Medical Report (Simple)	222.08	MN0149
	Specialist Medical Report (Complex)	458.41	MN0150
	Work Injury Compensation Initial Assessment Report*	203.74	MN0151
	Medico-Legal Medical Report (Simple)	712.86	MN0307
	Medico-Legal Medical Report (Complex)	1090.00	MN0308
	Forensic Report (Simple)	1222.44	MN0152
	Forensic Report (Complex)	2725.00	MN0154
Memorandum-Only the following criteria will be accepted			
	(i) Certification of diagnosis.	10.90	MN0350
	(ii) (A) Fit to work (B) Fit to drive (C) Fit for flight travel		
	(iii) Referrals to: (A) KTPH specialties (B) Laboratory/Radiology procedures		
	(iv) Memo for purchasing medical devices		
	(v) Very brief medical condition (eg. BP reading/height/weight)		

**Relevant form(s) must be provided*

PREFERRED MODE OF DISPATCH (Please Select One Only)

☐ **EMAIL**: Please specify recipient's email. No hard copy will be provided.

OR

☐ **COURIER MAIL WITHIN SINGAPORE ONLY ($10.19 (GST Incl) - Service Code: MN0135)**
Please specify recipient's name, address, and contact number for delivery.
Note: For failed courier delivery, recipient is required to collect the medical report or duplicated document at Patient Service Centre on Saturdays (excluding Public Holidays) between 8.30am to 12.30pm.

No courier service for overseas mail. Only registered mail for overseas postage ($10.19 (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) or if Yishun Health did not receive my consent form with supporting documents in its physical dropbox. 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