Health Information Management Services
Sengkang General Hospital (SKH)
110 Sengkang West Way
Singapore 544886
Tel: 6930 6003
medicalreports@skh.com.sg

APPLICATION FOR RELEASE OF PATIENT'S MEDICAL INFORMATION (FORM C)
CONSENT/LETTER OF UNDERTAKING FROM PATIENT'S NEXT-OF-KIN

INSTRUCTIONS

1. As the patient is deceased/mentally incompetent, written consent is required from the patient's authorised legal representative and/or appointed Deputy/Donee/Administrator of Estate for the release of the patient's medical information.
2. Authorised representatives are to provide photocopies of their NRIC or passport, Court Orders, Lasting Power of Attorney and/or other legal documents (where applicable).
3. If a legal representative and/or Deputy/Donee/Administrator of Estate have not been appointed, this form must be duly completed and signed by all the patient's immediate next-of kin. A copy of the patient's death certificate is required.
4. Photocopies of relevant documents (e.g. death certificate of patient, birth certificates of children above 21, marriage certificate, death certificate of spouse, divorce certificates, birth certificates of parents and siblings for unmarried patients and letters of appointment of Deputy/Donee/Administrator of Estate) are to be attached with the application as proof of relationship to the patient.
5. The hospital reserves the right to refuse a request for the release of patient medical information if it is found that such persons do not have the authority to make such requests.
6. The release of the medical information is subject to official approval.

PATIENT'S PARTICULARS

Name : _____

NRIC / HRN : _____ Contact No : _____

Address : _____

Date of Hospital Attendance: _____ Clinical Department: _____

DECLARATION OF NEXT OF KIN

I/We*,

	Name in Block Letters	NRIC No	Relationship to Patient
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

the surviving immediate Next-Of-Kin of the above named patient, hereby give my/our* consent and authorise Sengkang General Hospital to release the medical report/insurance claim form*

TO: Name of Company or Person : _____

Address of Company or Person : _____

FOR THE PURPOSE OF:

☐ Insurance Claims ☐ Legal Proceedings

☐ Others (please specify) _____

*Delete where appropriate

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I/We* hereby declare and confirm that I/we* am/are* competent to give the above consent and that the information given above is accurate and true to the best of my/our* knowledge, and that the requisite information is required for the sole purpose stated above. I/We* understand that I/we* may be liable for prosecution for making any false declaration herein. Further, I/we confirm that I/we* shall not hold Sengkang General Hospital or any of its employees, servants or agents liable in any way whatsoever for the release of the patient's medical information to any party by me/us* 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. By reason of the aforesaid, I/we* undertake full responsibility and liability arising from the release of the requisite information.

Duly Signed and Executed by:

	Name in Block Letters	Signature	Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

*Delete where appropriate