PARKWAY HOSPITALS SINGAPORE PTE LTD

☐ GEH ☐ MEH ☐ MNH ☐ PEH

CONSENT FOR RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS

In accordance with the Personal Data Protection Act (No.26 of 2012), this **application can only be made by the patient** unless the patient is (i) a minor, (ii) deceased or (iii) mentally incapacitated. The Hospital reserves the right to refuse a request for the release of patient medical information if the Hospital finds that such persons do not have the authority to make such requests. Please refer to Notes on the last page of this form for the required documents.

1. If the patient is a minor (who is below 21 years old, who is not an active National Serviceman, and who is not married or a widower or widow), the application is to be made by patient's parent(s) or legal guardian(s). The applicant who signs the form under "Part E – authorization" to give consent on behalf of the patient must ensure that he / she is authorised to act on behalf of the minor and that there are no court orders to the contrary.
2. If the Patient is deceased,
    a. The Application is to be made by the Legally Appointed Representative of the Estate. This is either an executor of the deceased's "Will" who has been granted probate, or a person who has been appointed as an administrator of the deceased's estate by the Singapore Court.
    b. If the deceased does not have a Legally Appointed Representative of the Estate, then the application is to be made by the deceased's Next-of-Kin (who is living and has the mental capacity to do so). The nearest relative is the individual first listed in the following order: (i) Spouse, (ii) Child, (iii) Parent, (iv) Sibling, (v) Other legal relations.
3. If the patient lacks mental capacity, and in accordance to the Mental Capacity Act (Cap 177A):
    a. The application is to be made by the Legally Appointed representative, who is a Donee of a Lasting Power of Attorney granted by the patient, or by a Deputy appointed for the patient by the court.
    b. If the patient does not have a Legally Appointed Representative of the Estate, then the application is to be made by the patient's Next-of-Kin (who is living and has the mental capacity to do).

PART A: PATIENT'S PARTICULARS	
Name (as in NRIC / Passport)	
NRIC / Passport Number	
Residential Address	
Contact Number	
Email address	
Period or Date of Visit	

PART B1: AUTHORISATION BY PATIENT ONLY UNLESS PATIENT IS A MINOR, DECEASED OR LACKS MENTAL CAPACITY
**Please refer to Instructions and Notes for eligible applicant.*

I,_____(name of patient/ applicant*) of NRIC / Passport Number_____hereby authorise PARKWAY HOSPITALS SINGAPORE PTE LTD to furnish and release the medical information indicated below to **myself / my Authorised Recipient (refer to Part D1)** (**delete where applicable**). I consent to having details in relation to my National Identification Number (NRIC, passport, birth certificate, foreign identification work permit number), including copies, to be collected, used and / or disclosed for the purpose of processing my request for medical information set out below. (Please tick accordingly):

☐ Discharge Summary ☐ Investigation Results ☐ Others (*Please specify*)

……..

PART B2: DETAILS OF THE APPLICANT – this section is not applicable if the request is made by the Patient
**Please refer to Instructions and Notes for eligible applicants*

Name	NRIC / Passport Number
Address	Contact Number
	Email address

PART C: PURPOSE OF REQUEST

☐ Insurance Claims	☐ Work injury compensation	☐ Continuity of Care
☐ Legal proceedings	☐ Second Opinion	☐ Others (Please specify):

PART D1: AUTHORIZED RECIPIENT – this section is not applicable if the medical information is to be released to patient / applicant (as named in PART B1)

Name	NRIC / Passport Number
Address	Contact Number
	Email address

PART D2: PREFERRED MODE OF COLLECTION
☐ I / my authorized recipient will collect the medical information personally in the hospital once it is ready. **I am aware that, I / my authorized recipient will need to produce NRIC for verification of identity during collection. Otherwise, the medical information cannot be released to individuals with unverified identity**.
☐ Please **post** the required medical information to the address of Patient / Applicant / Authorized Recipient (**please delete where applicable**) as indicated above.
☐ Please **email** the required medical information to Patient / Applicant / Authorized Recipient (**please delete where applicable**) as indicated above.

PART E: CONSENT		
By signing on the consent herein, I acknowledge that I have read and understand the Instructions and Notes on Consent for Release of Medical information. I confirm that I shall not hold Parkway or any of its employees, servants or agents responsible in any way whatsoever for the release of the said medical information (including to any other party authorised by me) in the event of any loss or damage arising directly or indirectly, as a result or in connection with the release of such medical information. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the said medical information.		
Signature of Patient / Applicant Date:	**Signature of Authorised Representative** *(Refer to "Instructions" before Part A of this form)* Date:	**Relationship to Patient**

NOTES ON CONSENT FOR RELEASE OF MEDICAL INFORMATION

1. Forms and supporting documents required are:
   a. Copy of the completed "Consent for Release of Medical Information".
   b. Scanned copies/photocopies of the patient's NRIC (or appropriate identification documents), both front and back views.
   c. **If the applicant is not the patient:**
      - Scanned copies/photocopies of the applicant's NRIC (or appropriate identification documents), both front and back views.
      - Scanned copies/photocopies of all relevant documents (e.g. Birth Certificate, Marriage Certificate, Grant of Probate, Letter of Administration, Lasting Power of Attorney, Order of the Court (Appointment of Deputy) as proof of the applicant's relationship to patient.
   d. **For deceased patient:** scanned copy / photocopy of the death certificate.
   e. **In addition for deceased or patient who lacks mental capacity, and for whom the applicant is the Next-of-kin:** Scanned copies/photocopies of the relevant verification documents (e.g. marriage certificates, birth certificates) are to be provided by each declaration (i.e. spouses/children/siblings) as proof of relationship to the deceased patient.

2. Parkway Hospitals Singapore Pte Ltd can only process your application / consent for release upon verification and receipt of all necessary forms and relevant supporting documents stated above.

3. Contact & Application Information:

Gleneagles Hospital (GEH) 6A Napier Road Singapore 258500 Tel : 6470 3450 Fax No: 6470 3446 Email : SG.GEH.MRO@gleneagles.com.sg	**Mount Elizabeth Hospital (MEH)** 3 Mount Elizabeth Singapore 228510 Tel : 6731 2237 Fax No : Nil Email : SG.MEH.MRO@mountelizabeth.com.sg
Mount Elizabeth Novena Hospital (MNH) 38 Irrawaddy Road Singapore 329563 Tel : 6933 0497 Fax No: 6933 0505 Email : SG.MNH.MRO@mountelizabeth.com.sg	**Parkway East Hospital** **(PEH)** 321 Joo Chiat Place Singapore 427990 Tel : 6340 8646 Fax No : 6340 8644 Email : SG.PEH.MRO@parkwayeast.com.sg

Operating Hours:
Monday – Friday: 8.30am – 5.30pm (last walk in request at 5.00pm)
Closed on Saturday, Sunday & Public Holidays