CONSENT FORM- MEDICAL INFORMATION

Type of Information / report requested :-

- ☐ Insurance Claims
- ☐ Discharge Summary
- ☐ EPF
- ☐ SOCSO
- ☐ Investigation Report
- ☐ Written Medical Report
- ☐ Hospitalization Report
- ☐ Medical Record
- ☐ Others :……..

Requestor's Details :-

- ☐ Self
- ☐ Next of Kin / Legal Representative (Relationship : ……..)
- ☐ Insurance Agent
- ☐ Others :……..

Additional Info:

- ☐ Verification with patient
- ☐ Compliance with PDPA

Date : ……..

CONSENT FOR RELEASE MEDICAL INFORMATION

I …… NRIC No / Passport No ……..……..…….

(Patient/ Next of Kin/ Legal Representative) (Patient/ Next of Kin/ Legal Representative)

of (address) ……..……..……..……..

……..

Hereby give consent to **ASSUNTA HOSPITAL** and its doctor /officers to disclose any information (in full or in part) concerning the medical condition of myself / patient name ……

(Patient/ Next of kin/ Legal Representative)

Patient NRIC No / Passport No …….…… to ……..

(Agency Name/Next of Kin)

for purpose of (specify) ……..……..

And hereby release the attending consultant and its staff from legal responsibilities or liabilities that may arise from the act hereby authorized.

……	……
Signature of Patient/Legal Representative/Next of Kin*	Signature of Witness
Name : ……..……..	Name : ……...
NRIC/Passport : ……..……	NRIC/Passport : ……..……
Contact No : ……..……..	Contact No : ……..……..

**This form to be signed bye the Parent/Guardian/next-of-kin of the patient if patient under 18 years of age, or has a mental incapacity to consent the release of medical information, or is deceased.*