CRAWFURDMEDICAL
CRAWFURD MEDICAL CENTRE PTE LTD (201434599D)
3 Temasek Boulevard, Suntec City Mall (North Wing between Tower 1 & 2), #02-482, Singapore 038983
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LETTER OF CONSENT FOR ANOTHER PERSON TO ACCESS MEDICAL RECORDS

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 parent or guardian.
2. The patient has to enclose a photocopy of his or her own NRIC (front and back) if submitting via mail, fax or email.
3. The release of the medical information is subject to official approval.

PATIENT'S PARTICULARS

Name (as in NRIC/Passport) : _____

NRIC : _____

Contact No. : _____

Mailing Address : _____

DECLARATION

I, _____, of NRIC No _____

am the above-named Patient / Parent / Next of Kin / Others (to specify) _____.

I hereby authorize Crawfurd Medical Centre Pte Ltd to disclose and release my protected health information described below to:

Name of Company or Person : _____

Address of Company or Person : _____

Health Information to be disclosed (Tick one option)

□ **Disclose my complete health record** (including but not limited to diagnoses, laboratory tests, prognosis, treatment, billing etc for all conditions **OR**

□ **Disclose** my health record, as above, **BUT do not disclose** the following (tick as appropriate):
- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse
- □ Others (please specify): _____

□ **ONLY disclose** the following information (please specify): _____

This authorization shall be effective until (Tick one option):
- □ Present and all future periods, **OR**
- □ Date or event: _____

Unless I revoke it. I understand that I may revoke this authorization by notifying Crawfurd Medical Centre in writing.

I am aware that this authorization letter with the authorized person's name and NRIC No. and a copy of my NRIC have to be furnished, otherwise my confidential medical information cannot be released.

I hereby declare and confirm that I am competent to give the above consent and that the information given above is accurate and true to the best of my knowledge. I understand that I may be liable for prosecution for making any false declaration. I confirm that I shall not hold Crawfurd Medical Centre Pte Ltd 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. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite information.

_____

Signature of Patient/Parent/Next of Kin or Others (specify relationship:_____) Date: _____