CRAWFURDMEDICAL

CRAWFURD MEDICAL CENTRE PTE LTD (201434599D)
3 Temasek Boulevard, Suntec City Mall (North Wing between Tower 1 & 2), #02-482, Singapore 038983
Telephone : 6804 9580 | Fax : 6341 9757 | Website: www.crawfurdmedical.com.sg

CONSENT FOR RELEASE OF MEDICAL INFORMATION

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. If the patient is deceased or unable to give consent, consent is required from the authorized representative. Where applicable, authorized representatives are to provide photocopies of their NRIC or passport or legal documents. If an authorized representative has not been appointed, a separate Letter of Undertaking has to be completed by all family members of the patient.
3. Patient has to enclose a photocopy of his or her own NRIC (front and back) if submitting via mail, fax or email.
4. Completed forms must be submitted with the appropriate fee. Cheques should be crossed and made payable to "**Crawfurd Medical Centre Pte Ltd**".
5. 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 furnish and release the below stated

TO: Name of Company or Person : ____________________

Address of Company or Person : ____________________

TYPE OF REQUEST (fees shown are not inclusive of prevailing GST)

- □ Ordinary Medical Report ($80-200)
- □ Specialist Medical Report ($120-300)
- □ Lab/X-ray results ($5 per result)
- □ Duplicate Copy of Medical Report ($10-30)
- □ Insurance Form ($80-200) (please attach copy of form)
- □ Others (please specify): ____________________

FOR PURPOSE OF:

- □ Continuation of Care
- □ Insurance Proposal
- □ Insurance Claim
- □ Others (please specify): ____________________

Besides the medical report fee, I undertake to pay any additional charges such as X-ray and/or laboratory investigation charges that may be incurred in the preparation of the report. I am also aware that there will be a cancellation charge of 50% of the medical report fee should I decide to cancel this request.

PREFERRED MODE OF COLLECTION

- □ I will personally collect the report once it is ready. My contact number is ____________________.
- □ Send to my mailing address as stated above.
- □ Send to the address of the company or person as stated above.
- □ The report will be collected by my representative. **I am aware that an authorization letter with the representative's name and NRIC No. and a copy of my NRIC have to be furnished upon collection and that the medical report cannot be released otherwise**.

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, and that the requisite information is required for the sole purpose stated above. 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.

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