Medical Records Office (IMH)
10 Buangkok View
Singapore 539747
Email: mro_imh@imh.com.sg

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION (MEDICAL REPORT)

Notes:

1. This form must be duly signed by the patient and completed with witness' details and signature. If patient is below 21 years old, the form should be signed by patient's parent or legal guardian.
2. If the patient is deceased or mentally incompetent, consent is required from the appointed representative. Relevant documents such as photocopies of NRIC, birth certificate, marriage certificate, letter of administrations such as Court appointment on Deputyship, Lasting Power of Attorney) are required to proof the relationship to patient. A copy of patient's death certificate is required.
3. Patient to enclose a photocopy of NRIC (front & back view) for verification purpose.
4. The release of medical report is subjected to official approval.

PATIENT'S PARTICULARS

Full Name (*As in NRIC/Passport) _____

NRIC / FIN No _____ Contact Number _____

Mailing Address
(for courier option) _____

Note: For self-application, medical report will be sent to patient's registered address with IMH unless otherwise instructed.

REQUEST

I, _____ of *NRIC/Passport No _____

hereby authorise INSTITUTE OF MENTAL HEALTH (IMH) to furnish and release the medical information on:

☐ Myself ☐ My Dependent (e.g. son/daughter) _____

To: Organisation/Person (Name) _____

Address (for courier) _____

Note: For self-application, medical report will be sent to patient's registered address with IMH. For organisation address, please provide the full address of the organisation)

Purpose ☐ Continuity of Care ☐ Legal Proceedings ☐ Second Opinion

☐ Insurance Claims ☐ Others (Please specify) _____

Remarks _____

In addition to the medical report fee, I undertake to pay any additional charges that may be incurred in the preparation of the report including psychological assessments and laboratory tests ordered by the Doctor. I am also aware that there will be a cancellation charge if I cancel this request. Full medical fee applies if the medical report has been completed at the point of cancellation. Cheque/bank draft should be crossed and made payable to "Institute of Mental Health". Kindly indicate the patient's name, NRIC (last 4 letters) and the contact number on the back of the cheque.

COLLECTION / MAILING OPTIONS

☐ I will personally collect the medical report. Please call me on _____ (mobile number/contact number).

☐ To receive a softcopy of the medical report (file protection with password) via email.

☐ To mail out via Courier. I undertake to pay the Courier fee of $6.50.

(Note: I acknowledge that the medical report will be collected by anyone who collects the mail from courier. If no one is to receive the mail, I agree that the Courier can leave the mail at the unit number as stated on the mail. If I wish to collect it personally from the courier at a designated time, please notify Medical Records Office and additional courier fee will apply)

SIGNED CONSENT

I hereby declare and confirm that the information given above is accurate and true to the best of my knowledge. and belief, and that the requisite medical information/medical report is required for the purpose stated above. I understand that I may be liable for prosecution for making a false declaration. Further, I confirm that I shall not hold the Institute of Mental Health (IMH) or any of its employees, servants or agents responsible in any way whatsoever for the release of the said medical information / medical report to any party 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 confidentiality medical information / medical report. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite medical information/medical report.

Date: _____

Name _____
Relationship to Patient _____
Contact _____
(For MCA Form 224, please indicate name and signature of applicant and indicate relationship to patient)

Date: _____

Witness Name and NRIC _____
Relationship to Patient _____
Contact _____