National University Polyclinics

MEDICAL REPORT CONSENT AND APPLICATION

Instructions

1. This form must be fully completed for the application of a medical report. It should be signed by the patient / requestor and be duly witnessed or verified. A completed form is only valid for a period of 6 months from the signed date.
2. If request is by next-of-kin, proof of relationship with patient shall be provided, and shall seek Doctor's verification to substantiate claim that patient is incapable of authorising the request.
3. Photocopies of relevant documents (e.g. NRIC, birth certificate, marriage certificate and letters of administration) are to be attached as proof of relationship to patient if applicable. This form is to be submitted with the appropriate report fee plus delivery charges if applicable. Please note that once payment has been processed, should requestor choose to cancel the application, **no refund** will be issued.
4. The release of the medical report is subject to official approval.

Requestor's Detail

Please indicate your relation to the patient based on the selections provided below:

- ☐ Patient (self)
- ☐ Patient's Appointed Estate Administrator (if patient is deceased)
- ☐ Parent of Minor (if patient is below 21 years of age)
- ☐ Patient's Appointed LPA Donee (where patient is incapable of authorising the request)
- ☐ Others/ Authorised Representative (please specify): _____

Patient's Particulars

Given Name (As in *ID/Birth Cert/Passport): _____ ID No.: _____

National University Polyclinics: _____ (To Specify Clinic Location)

Date(s) of Clinic Attendance (for which this application for medical information is to cover):

_____

Declaration

I, _____ (Name), ID no. _____ hereby authorize National University Polyclinics to furnish and release the chosen report(s) below:

- ☐ Ordinary Medical Report
- ☐ Completion of Insurance Form (please attach a copy of insurance claim or insurance proposal form)
- ☐ Duplicate Copy of Medical Report
- ☐ Others (please specify): _____

For: ☐ Myself ☐ My Dependent: _____ (Please specify relationship) ☐ My Estate ☐ My Donor

To: Authorised Representative (Indicate NA if not applicable)

Name of *Company / Person: _____

Address of *Company / Person: _____

For the purpose of: _____

Besides the medical report fee, I agree to pay for any additional charges, such as X-ray and Laboratory Investigation Charges, which may be incurred in the preparation of the medical report.

Preferred Mode of Delivery

- ☐ **Self-collect by Requestor:** I will personally collect the report once it is ready. **I am aware that I will need to produce my ID for staff to sight and verify, and the medical report cannot be released if I am unable to do so**.

- ☐ **Collection by Authorised Representative:** The report will be collected by my authorised representative. **He/ She must produce the required documents on the day of collection** and that the medical report cannot be released if he/she is unable to do so – Please complete "Authorisation for Collection of Medical Report" form.

- ☐ **Registered Mail/ Courier:** Send the report to the address of Requestor by *^Registered Mail/ Courier. Mailing Address: _____

- ☐ **Email:** Send the report to requestor's email address: _____

_____ _____

Name of Patient/ Requestor (in BLOCK LETTERS) Signature of Patient/ Requestor & Date

*Delete as appropriate

^Additional charges (inclusive of prevailing GST) may apply for sending of report through registered mail/courier