KK Women's and Children's Hospital
SingHealth

HEALTH INFORMATION MANAGEMENT SERVICES
(MEDICAL REPORTS UNIT)
TEL: (65) 63941209 (Mon-Fri 8.30am to 5pm)

CONSENT FOR RELEASE OF MEDICAL INFORMATION

1 Identification Documents required

a) Patient 21 years and above	▪ Patient's NRIC (front & reverse) ▪ Valid passport or identification document issued by Singapore authorities (for non-residents)
b) Patient below 21 years old	▪ Patient's Birth Certificate ▪ 1 Parent's NRIC (front & reverse) ▪ Valid passport or identification document issued by Singapore authorities (for non-residents)
c) Other supporting documents if applicable (insurance form, court documents etc)	

2. All the fields in the consent form are mandatory and to sign by the patient OR parent/ legal guardian for patients below 21 years old.)
3. Incomplete form and non-payment will result in processing delays.
4. Release of medical information is subject to final approval by the Hospital.
5. Please email to "Insurance.GenEnquiry@kkh.com.sg" upon completion of this consent form together with the identification documents &/ or others supporting documents.

Patient Particulars

Name (As in NRIC/ Birth Certificate): _____ NRIC/ BC/ HRN No: _____

Doctor/ Specialty/ Clinic/ Ward: _____ Visit/ Admission Date: _____

Patient Authorisation

I, _____ NRIC No: _____
hereby authorize **KK WOMEN'S & CHILDREN'S HOSPITAL Pte Ltd** to furnish and release the requested medical information and/ or report(s).

Relation to Patient: ☐ Myself ☐ Mother ☐ Father Others (Please specify): _____

Please tick the report(s) requested:

Report Type	Fees S$ (Inclusive 9% GST)	Please tick
Ordinary Medical Report / Completion of Insurance Form	S$141.70	☐
Specialist Medical Report / Completion of Insurance Form with Question(s) on Prognosis	S$294.30	☐
Ordinary Medical Report (Psychiatric)	S$264.90	☐
Specialist Medical Report (Psychiatric) with Question(s) on Prognosis	S$489.00	☐
Duplication of Inpatient Discharge Summary	S$12.00	☐
Duplication of Laboratory Results/ Investigation Reports	S$12.00	☐
Duplication of Day Surgery Authorisation Form	S$12.00	☐
Duplication of Referral Letter	S$12.00	☐
☐ Others Report (Please specify):		

Purpose of the requested report(s):
☐ Insurance ☐ Legal Proceedings ☐ Continuity of Care ☐ Second Opinion Others (Please specify): _____

Completed Medical Report will be encrypted and sent to the email address provided below. No hard copy will be mailed.

Recipient Name: _____ # Recipient Email Address: _____

Payment instructions will be sent to the email address provided below within 3 working days from date of receipt of application.

☐ Use the Recipient Email Address stated above # ☐ Use this Email Address: _____

I undertake to pay the specified charges for the application of medical information. Should I cancel the application once it has been processed, there will be no refund of payment.
Fees are in SGD and apply to Singapore Citizen and Permanent Resident only. Fees are correct at the point of printing and subjects to changes without prior notice.
I declare the information given above is accurate and true. I understand I may be liable for prosecution for making a false declaration herein.

_____ _____
Signature of Patient/ Parent (if patient is below 21 years old) Date

FOR OFFICIAL USE

Verified By (Staff Name/ Signature/ Date): _____ MR No: _____