**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 or the patient’s parent (if patient is below 21 years of age) or the patient’s estate administrator(s) kin (if patient is deceased), and be duly witnessed.
2. Photocopies of relevant documents (e.g. 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. Please note that there will be **no refund** upon cancellation once payment has been made. Upon cancellation, the medical report will still be prepared and made available for collection.
3. The release of the medical report is subject to official approval.

|  |
| --- |
| Patient’s Particulars |
| Given Name (As in \*NRIC / Passport): |  | NRIC No.: |  |
| Address: |  |
| Date of Clinic Attendance:(for which this application for medical information is to cover) |  | Polyclinic: |  |
|  |  |  |  |
| Declaration |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NRIC/Clinic Registration No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize National University Polyclinics to furnish and release the chosen report below |
| * Ordinary Medical Report
 | * Duplicate Copy of Medical Report
 |
| * Completion of Insurance Form (please attach a copy of insurance claim or insurance proposal form)
 | * Memo
* Others (please specify):
 |
| FOR: | * Myself
 | * My Dependent
 |  |
|  |  | (please specify relationship): |  |
| TO: | Name of Company or Person: |  |
|  | Address of Company or 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:** I will personally collect the report once it is ready. **I am aware that I will need to furnish my NRIC upon collection and that the medical report cannot be released if I am unable to do so.**
* **Collected by Representative:** The report(s) will be collected by my representative. **I am aware that I have to produce the required documents required on the day of collection** and that the medical report cannot be released if I am unable to do so. Please complete “Authorisation for Collection/Application of Medical Report” form.
* **Mail:** Send to the address of Patient/ Representative\* (Delete accordingly) as indicated by Normal / Local registered mail/ courier\*^ (Delete accordingly)
 |
|  |  | Name (in block letters): |  |
| Signature of Patient/Parent/Next-of-kin |  | Relation to patient: |  |

\*Delete as appropriate

^Additional charges may apply for sending of report through local registered mail/courier

**AUTHORISATION FOR COLLECTION/ APPLICATION OF MEDICAL REPORT**

Note

This form is required if a representative is collecting the completed medical report on behalf of the applicant of “Medical Report Consent and Application” form.

Representative’s relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative’s contact no.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Letter of Authorisation |
| I,  |  | (patient’s name), |  | (patient’s NRIC) |
| hereby appoint |  | (representative’s name) |  |
| (representative’s NRIC) as my representative, and authorise him / her\* to 🞎 apply/ 🞎 collect the medical report. |
|  |
| I am aware that he/ she\* is required to produce the following documents on the day of collection:* This signed authorisation letter
* His/ her NRIC (for verification only)
* My NRIC (for verification only)
 |
|  |  |  |
| Representative’s Signature & Date |  | Patient’s Signature & Date |
|  |  |  |
| For authorisation for application of medical report:* Representative has enclosed scanned copies / photocopies of all relevant documents (e.g. Birth Certificate, Marriage Certificate, Letter of Administration, Lasting Power of Attorney, Order of the Court (Appointment of Deputy) as proof of the representative’s relationship to patient.
 |
| * Address of representative if “Preferred Mode of Delivery” is by mail:
 |  |
|  |  |

\*Delete/select as appropriate