National Healthcare Group
POLYCLINICS

CONSENT FOR RELEASE OF MEDICAL INFORMATION BY ALL CHILDREN / SIBLINGS

(FOR PATIENT WHO IS UNABLE TO GIVE CONSENT / DECEASED PATIENT)

Instructions:

1. **<u>If Patient lacks mental capacity to give consent:</u>**
    a. **Applicant must first check if patient has an existing Lasting Power of Attorney (LPA) with the Office of Public Guardian's (OPG)** e-registry and provide OPG's evidence of the confirmation that LPA does not exist.
        i. **If LPA exists, this form cannot be used.** LPA must instead be provided, and all medical requests should only be via Donee (who must also be granted the rights to patient's medical matters).
        ii. **If LPA does not exist**, applicant to provide proof from OPG and may use this consent form (see Instruction 2).
2. **<u>If Patient is deceased and there is no Legally Appointed Representative or Spouse, or classified as above Point 1(a) ii,</u>**
    a. *According to Intestate Succession Act Section 7, a*ll children / siblings* of the patient shall declare in Section 1 of the form. The appointed representative of the patient's children / siblings* is to fill up Section 2 of the form and ensure that all documents are provided:
        i. Proof of relationship (e.g birth certificate, etc) of all signatories must be provided.
        ii. A doctor's letter to ascertain the patient's condition must be provided. For deceased patients, to provide a copy of death certificate.
3. **This form serves as consent to release the patient's medical information.**

1. DECLARATION FROM ALL CHILDREN / SIBLINGS* OF THE PATIENT

We, *the children / siblings of (Patient's Name): _____ of *NRIC/FIN No _____ hereby authorise NATIONAL HEALTHCARE GROUP POLYCLINICS to furnish and release the medical information of the above-mentioned patient. By reason of the aforesaid, we undertake full responsibility and liability arising from the release of the medical information.

_____
Signature of Patient's Next-of-Kin
Name: _____
NRIC: _____
Relationship: _____

_____
Signature of Patient's Next-of-Kin
Name: _____
NRIC: _____
Relationship: _____

_____
Signature of Patient's Next-of-Kin
Name: _____
NRIC: _____
Relationship: _____

_____
Signature of Patient's Next-of-Kin
Name: _____
NRIC: _____
Relationship: _____

_____
Signature of Patient's Next-of-Kin
Name: _____
NRIC: _____
Relationship: _____

_____
Signature of Patient's Next-of-Kin
Name: _____
NRIC: _____
Relationship: _____

2. REPRESENTATIVE OF ALL CHILDREN / SIBLINGS

I, _____ of *NRIC/FIN No. _____ am appointed by the above-mentioned *children/ siblings of (Patient's Name): _____ of *NRIC/FIN No: _____ as the representative for the release of the medical information of the patient. I hereby declare that the above contents are true to the best of my knowledge, information and belief. I understand that legal action may be taken against me for any false statement(s) made. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of such medical information of the patient as requested.

_____ Signature of Appointed Representative

_____ Date

*Delete where applicable.