AUTHORISATION TO RELEASE MEDICAL RECORDS

INSTRUCTIONS

1. This form must be duly completed and signed by the patient. If the patient is below 21 years old, the form should be signed by the patient's parent.
2. If the patient is deceased / incompetent, consent is required from the authorised representative. Authorised representatives are to provide photocopies of their NRIC or passport, Court Orders, Lasting Power of Attorney and / or other legal where applicable. A copy of the patient's death certificate is required. If an authorised representative has not been appointed, a separate Authorisation to Release Medical Records has to be completed by all family members of the patients.
3. Photocopies of relevant documents (e.g. birth certificate, marriage certificate and letters of administration) are to be attached as proof relationship to patient if applicable.
4. Completed form must be submitted with appropriate fee.
5. The Aesthetic Studio Clinic and Surgery reserves the right to refuse a request for the release of patient medical information if The Aesthetic Studio Clinic and Surgery finds that such persons do not have the authority to make such requests.
6. The release of medical information is subject to official approval.

PATIENT'S PARTICULARS

Name (as in NRIC/Passport) _____

NRIC _____

Address _____

_____

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

Clinic _____

DECLARATION

I, _____ NRIC. No. _____ am the above-named Patient / Parent / Next of Kin / Administrator of Estate / Donee / Deputy* of the above-named patient. I hereby authorize The Aesthetic Studio Clinic and Surgery to furnish and release the below stated report:

TO: Name of Company or Person: _____

Address of Company or Person: _____

AESTHETIC STUDIO

CONFIDENTIAL INFORMATION

TYPE OF REQUEST:

- ☐ Specialist Medical Report ($300.00)
- ☐ Duplicate of Specialist Medical Report ($10.00/copy)
- ☐ Duplicate copy of Medical Report ($5.00/copy)
- ☐ Completion of Insurance Form **by Dr. Jonathan Lee** ($100.00), please attach a copy of Insurance claim or Insurance proposal form
- ☐ Completion of Insurance Form **by staff** ($50.00), please attach a copy of insurance claim or Insurance or Insurance proposal form
- ☐ Photos Taken
- ☐ Face Sheets / Body Charts
- ☐ Consultation Report
- ☐ Operative reports
- ☐ Copy of Medical Certificates/ Referral Letter / X-Rays images / Day Surgery Discharge / Lab Results ($10.70/copy)

_____

- ☐ Others (please specify):

_____

FOR THE PURPOSE OF:

- ☐ Third Party Claim
- ☐ Continuation of Claim
- ☐ Insurance Claim
- ☐ Insurance Proposal
- ☐ Second Opinion
- ☐ Legal Proceedings (please specify):

_____

- ☐ Others (please specify):

_____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

PREFERRED MODE OF DELIVERY

- ☐ I will personally collect the report once it is ready. **I am aware that I will need furnish my NRIC upon collection and that the medical report cannot be released if I am unable to do so.** My contact number is

_____; please E-mail me at: _____

- ☐ Send to the address indicated above.
- ☐ Send to the **local** address of the company or person as stated above.
- ☐ Send to the **overseas** address of the company or person as stated above. ($10.00)
- ☐ The reports will be collected by my representative. **I am aware that an authorisation letter with the representative's name and NRIC number and a copy of my NRIC has to be furnished upon collection and that the medical report cannot be released if I am unable to do so.**

#CDs/films not collected within 3 months of request date will be destroyed and future similar requests will be chargeable.

I hereby declare and confirm that I am competent to give the above consent and that the information given is accurate and true to the best of my knowledge, and that the requisite information for the sole purpose stated above. I understand that I may be liable for prosecution for making any false declaration herein. Further, I confirm that I shall not hold The Aesthetic Studio Clinic and Surgery or any of its employees, servants or agents liable in any way whatsoever for the release of the said medical information to any party by me in the event of any loss or damage arising directly or indirectly as a result of, or in connection with the release of such confidential information. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requisite information.

Signature of Patient & Date	***Signature of Patient / Next of Kin / Administrator of Estate / Donee / Deputy* & Date (Refer to instruction 1 & 2)***	***Relationship to Patient***

THE AESTHETIC STUDIO CLINIC & SURGERY

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