

**FORM B – APPLICATION FOR RELEASE OF PATIENT’S MEDICAL INFORMATION  
LETTER OF UNDERTAKING FROM PATIENT’S NEXT-OF-KIN**

**INSTRUCTIONS**

1. As the patient is deceased/mentally incompetent, written consent is required from the patient’s authorised legal representative and/or appointed Deputy/Donee/Administrator of Estate for the release of the patient’s medical information.
2. Authorised representatives are to provide photocopies of their NRIC or passport, Court Orders, Lasting Power of Attorney and/or other legal documents (where applicable).
3. If a legal representative and/or Deputy/Donee/Administrator of Estate have not been appointed, this form must be duly completed and signed by all the patient’s immediate next-of-kin. A copy of the patient’s death certificate is required.
4. Photocopies of relevant documents (e.g. death certificate of patient, birth certificates of children above 21, marriage certificate, death certificate of spouse, divorce certificates, birth certificates of parents and siblings for unmarried patients and letters of appointment of Deputy/Donee/Administrator of Estate) are to be attached with the application as proof of relationship to the patient.
5. The release of the medical information is subject to official approval.

**PATIENT’S PARTICULARS**

Name : \_\_\_\_\_ NRIC / FIN / HRN: \_\_\_\_\_  
 Address : \_\_\_\_\_ Postal Code : \_\_\_\_\_  
 Email : \_\_\_\_\_ Contact No. : \_\_\_\_\_  
 Surgery / Visit Date : \_\_\_\_\_

**DECLARATION OF NEXT-OF-KIN**

I/We\*,

No.	Name in Block Letters	NRIC No.	Relationship to Patient
1			
2			
3			
4			
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10			

the surviving immediate Next-Of-Kin of the above named patient, hereby give my/our\* consent and authorise Singapore National Eye Centre to release the medical report/insurance claim form\*

TO: Name of Company or Person : \_\_\_\_\_  
 Address of Company or Person : \_\_\_\_\_

**FOR THE PURPOSE OF:**

Insurance Claims       Legal Proceedings       Others (please specify) \_\_\_\_\_

\*Delete where appropriate

**APPLICATION FOR RELEASE OF PATIENT'S MEDICAL INFORMATION  
CONSENT/LETTER OF UNDERTAKING FROM PATIENT'S NEXT-OF-KIN**

I/We\* hereby declare and confirm that I/we\* am/are\* competent to give the above consent and that the information given above is accurate and true to the best of my/our\* knowledge, and that the requisite information is required for the sole purpose stated above. I/We\* understand that I/we\* may be liable for prosecution for making any false declaration herein. Further, I/we confirm that I/we\* shall not hold Singapore National Eye Centre or any of its employees, servants or agents liable in any way whatsoever for the release of the patient's medical information to any party by me/us\* 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/we\* undertake full responsibility and liability arising from the release of the requisite information.

**Duly Signed and Executed by:**

No.	Name in Block Letters	Signature	Date
1			
2			
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**DOCUMENT CHECKLIST FOR PATIENTS WITH NO APPOINTED LEGAL REPRESENTATIVE**

**Married Patients**

- Death certificate, if deceased
- Marriage certificate
- Birth certificates of all children, if any
- Death certificates of spouse, if applicable
- Divorce certificate, if applicable

**Single Patients**

- Death certificate, if deceased
- Parents' marriage certificate
- Birth certificate of all siblings

\_\_\_\_\_

SNEC Reference No.

\_\_\_\_\_

Receipt No.

\_\_\_\_\_

Processed By & Date

*\*Delete where appropriate*