Additional Declaration for Release of Medical Information for Patient with Mental Incapacity (Form D)

This application for release of medical information is made to the institution of the National University Health System Pte. Ltd ("**NUHS**") group indicated below (the "**Institution**"). Please choose only **ɑ** e institution.

☐ Alexandra Hospital	☐ National University Hospital	☐ Ng Teng Fong General Hospital
☐ Jurong Medical Centre	☐ Jurong Community Hospital	

The medical information released will only be for the Institution indicated, and the release of the medical information is subject to the approval of the Institution.

Note:

- This Form D is required for Applicants who are applying on behalf of a patient with no mental capacity, and should be read together with Form A.
- The Applicant should be Patient's Legally Appointed Representative.
- Where the Applicant is not a Legally Appointed Representative, the Applicant should be a Close Relative as prioritised as follows: Spouse, child, sibling, other relative.
- No applications by a Close Relative for the purpose of contentious court proceedings is allowed without a court order.
- Scanned copies / photocopies of the relevant verification documents (e.g., marriage certificates, birth certificates) are to be provided by each declarant (i.e., spouses / children / siblings) as proof of relationship to the patient who lacks mental capacity.
- Applications by a Close Relative for purposes other than those specifically listed in Section 1 require declarations from other Close Relatives. Please refer to Section 2.

Section 1 – Declaration

I, (name)_____(NRIC)_____(the "**applicant**") am the (relationship to patient) _____, of the patient (name)_____(NRIC)_____.

1. I, the undersigned, hereby declare and confirm that:

   a) I have submitted supporting documents in this application that show that the Patient lacks mental capacity and is unable to make decisions about his / her personal welfare and healthcare decisions;

   b) I am:
      a. ☐ The Patient's Legally Appointed Representative
      b. ☐ A Close Relative

   For Close Relative only: I am not aware of any formally appointed Donee under a Lasting Power of Attorney (LPA) or a Deputy by the Singapore Courts for the management of Patient's welfare; and

   c) I require a copy of the following medical information for the stated purpose only:
   ☐ Mental Capacity Act (MCA) Medical Report (Form 224)
   ☐ Medical Report for Activation of LPA
   ☐ Investigation results/discharge summary for the purposes of obtaining and second opinion/transfer of care/continuity of care/others_____
   ☐ Detailed Normal/Specialist medical report for insurance claims
   ☐ Others (please specify type of medical report and purpose, please complete Section 2)
   _____

2. I hereby further declare that the information I have provided in this Form is true and accurate to the best of my knowledge and belief, and I am acting in the Patient's best interest. I understand that legal action may be taken against me for any omission(s) or false statement(s) made.

3. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the requested medical information by the Institution. and shall indemnify the Institution against any liability, demand, claims, losses and legal costs incurred due to false statements or omissions by me in procuring the medical information of the Patient.

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Applicant's Signature
Date:

Explained by:

Signature of Staff
Name:
Date:

Section 2 – Consent & Declaration from All Other Living Spouses / Children / Siblings / other relations

We, the *spouse / children / siblings / other relations (delete accordingly) of (mentally incapacitated patient's name) _________________________ (mentally incapacitated patient's NRIC)_____________________hereby authorise the Institution to furnish and release the requested medical information of the abovementioned patient to the applicant, for the reasons stated in Section 1 above. I undertake full responsibility and liability arising from the release of the requested medical information by the Institution and shall indemnify the Institution against any liability, demand, claims, losses, and legal costs incurred due to false statements or omissions by me in procuring the medical information of the Patient.

Name:	Name:
NRIC No.:	NRIC No.:
Relationship to Patient:	Relationship to Patient:
Signature & Date:	Signature & Date:

Name:	Name:
NRIC No.:	NRIC No.:
Relationship to Patient:	Relationship to Patient:
Signature & Date:	Signature & Date:

Name:	Name:
NRIC No.:	NRIC No.:
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NUHS National University Health System

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