

## Additional Consent & Declaration for Release of Medical Information of Deceased Patient (Form C)

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 one 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 is required if the applicant of "Application & Consent for Release of Medical Information" (i.e. "Form A") is the nearest relative of the deceased patient, as defined under the Personal Data Protection Act (No.26 of 2012) in the absence of a Legally Appointed Representative.
- Section 1 is to be filled by the Applicant.
- Section 2 is to be filled by all living spouses / children / siblings (other than the Applicant) of the deceased patient, if the Applicant is not the only living spouse / child / sibling.
- 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 deceased patient.
- Use additional copies of this form if the space provided is insufficient.

### Section 1 – Declaration from the Applicant

I, (name) \_\_\_\_\_ (NRIC) \_\_\_\_\_ am the nearest relative of the deceased patient (name) \_\_\_\_\_ (NRIC) \_\_\_\_\_.

- I hereby declare that the deceased has no Will and there is no Legally Appointed Representative of the deceased.  
 I hereby declare that I am the only living \*spouse / child / sibling (delete accordingly) of the deceased patient.  
 I hereby declare that I am not the only living \*spouse / child / sibling (delete accordingly) of the deceased patient, and therefore declare that the contents below 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 deceased patient as requested.

Signature & Date: \_\_\_\_\_

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

We, the \*spouse / children / siblings (delete accordingly) of (Deceased patient's name) \_\_\_\_\_ (deceased patient's NRIC) \_\_\_\_\_ hereby authorise the Institution to furnish and release the medical information / medical report of the abovementioned patient. By reason of the aforesaid, we undertake full responsibility and liability arising from the release of the medical information.

Name:

NRIC No.:

Relationship to Patient:

Signature & Date:

Name:

NRIC No.:

Relationship to Patient:

Signature & Date:

Name:

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Relationship to Patient:

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