Picaso
HOSPITAL PICASO

Patient's Name:		Patient Label
MRN:	Location:	
Age:	Gender:	
Visit No.:	Date:	

RELEASE OF PATIENT INFORMATION FOR MEDICAL REPORT(S)

Requestor's Details

Requestor Name : _____
NRIC No/Passport No : _____ Contact No:_____
Relationship to patient:

- ☐ Self
- ☐ Next of Kin / Immediate Relative (Relationship : _____)
- ☐ Insurance Agent (Company Name :_____)
- ☐ Legal Firm (Company Name : _____)
- ☐ Others: _____

Type of Information / Report Requested

- ☐ Insurance Form ☐ Discharge Summary ☐ EPF ☐ SOCSO
- ☐ Investigation Report ☐ Written Medical Report ☐ Hospitalization Report
- ☐ Others:_____

Method of Release

- ☐ Self-Collection by requestor or patient (authorization letter required if collection by third party)
- ☐ Email to:_____
- ☐ Courier to the following address (fee applies) :

_____
_____

Patient's Particular

Patient Name:_____ MRN NO:_____
NRIC/Passport:_____ Contact No:_____

Declaration and Authorization

I, the above name / next of above-named / legal representative of the above-named patient, declare that the information provided above is true and correct to the best of my knowledge, and where applicable, do hereby expressly authorize PJ Integrated Centre for Advanced Surgery and Oncology (PICASO) to release the patient's medical reports(s) as well as any / all information pertaining to diagnosis and / or treatment given and / or received at Hospital Picaso to the requestor stated above through the preferred method of release I have chosen above. In the event I choose of release other than self-collection, I accept the following: -

a) that the hospital advises me to collect the medical reports) in person but choose to have the medical reports(s) sent / release by the means I selected above;
b) that I understand and accept that there is a risk of my personal and confidential information being delivered to unintended recipients;
c) that I understand there is a risk of my personal and confidential information being hacked, leaked, lost or destroyed;
d) that I shall not hold Hospital Picaso responsible for consequential losses, damages, loss of reputation or any other types of losses as a result of my choice of delivery / release of the medical report(s)

I have read and agree that my personal information set out in this form will be collected and processed accordance PHospital Picaso / in accordance to PDPA 2010. I further undertake to settle all the cost and expenses incurred therein and release Hospital Picaso and its employee from any liabilities howsoever arising thereto.

_____
Signature Patient

_____
Signature of Next of Kin / Legal Representative
* This section is to signed by the Parents / Guardian / Next of Kin of the patient if the patient a Minor (under 18 years of age) or has a mental incapacity to consent for the release of information, or deceased

Name : _____
NRIC/Passport No : _____
Date : _____

Name:_____
NRIC/Passport No:_____
Date:_____

***Patient compulsory to sign at this**