

CONSENT FOR RELEASE OF INFORMATIONPlease where applicable**1. Requester Information**

Name of Requester: _____

Relationship with Patient: _____

 Identity Card No.: _____ Passport No.: _____

House Tel. No.: _____ Mobile No.: _____

Address of Requester: _____
_____**2. Patient / Deceased Information**_____
Name: _____ Registration Number _____ NRIC / Passport Number _____Gender: Male Female**3. Report Requested For :** Hospitalisation Claim Report Full Medical Report Investigation Report Medical Photographs Other Reports, please specify : _____**4. Patient / Next of Kin's Consent for Release of Reports**

I hereby authorise Island Hospital to release the Medical Record / Information of self / patient / deceased as stated in section two (2) to the requester as stated in section one (1).

In consideration of the above, I hereby undertake to indemnify Island Hospital against any loss or liability in the event of any claims whatsoever arising in consequences of the above.

Patient / Next of Kin**Witness**

Signature: _____ Signature: _____

Name: _____ Name: _____

Identity Card/Passport No.: _____ Identity Card /Passport No.: _____

Date: _____ Date: _____