

LETTER OF UNDERTAKING FOR PATIENT'S NEXT-OF-KIN (FOR PATIENT WHO IS UNABLE TO GIVE CONSENT/ DECEASED PATIENT)

Notes:

1. This form is required if the applicant of "Application & Consent for Release of Medical Information" is the nearest relative of the deceased patient/patient who lacks mental capacity in the absence of a Legally Appointed Representative.
2. If the patient is mentally incapacitated, supporting documents that show that the patient lacks mental capacity are to be submitted by the applicant.
3. Scanned copies/photocopies of relevant documents (e.g. death certificate of patient, birth certificates, marriage certificate, grant of probate, letters of administration) are to be provided by each declarant (e.g. spouse/ parent/ children/ siblings) as proof of relationship to the patient.
4. The release of the medical information is subject to official approval.

SECTION 1 – DECLARATION BY APPLICANT

I, (Name as in *NRIC/Passport) _____ of Identification No. _____
_____ am the (relationship to patient) : _____ of the patient
(Name) _____ of Identification No. _____

I, the undersigned, hereby declare that:

- [If the patient is mentally incapacitated]** I am not aware of any formally appointed Donee under LPA or a Deputy by the Singapore Courts for the management of Patient's welfare. I *have obtained / am unable to obtain** consent and declaration from all other living spouse / children / parent / siblings as listed in Section 2 below.
- [If the patient is deceased]** I am not aware of any Will or any Legally Appointed Representative of the deceased. I *have obtained / am unable to obtain** consent and declaration from all other living spouse / children / parent / siblings as listed in Section 2 below.
- [Section 2 is not applicable]** I am the only living next of kin for patient.

*Delete where appropriate. Where the applicant is unable to obtain consent from all other living spouse / children / parent / siblings, please furnish reasons in Section 2.

The above contents 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 for the release of such medical information of the patient as requested.

Signature of Applicant

Relationship to Patient

Date

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SECTION 2 - CONSENT & DECLARATION FROM ALL LIVING SPOUSE / CHILDREN / PARENT / SIBLINGS

We, the *spouse / children/ parents / siblings of (Patient's name as in *NRIC/Passport) _____ of Identification No. _____ hereby authorise Woodlands Health to furnish and release the medical information of the above-mentioned patient to the Applicant named in the Application & Consent for Release of Medical Information. By reason of the aforesaid, we jointly and severally undertake full responsibility and liability arising from the release of the medical information.

Signature of Patient's Next-of-Kin

Name:
NRIC:
Relationship:
Reason if unable to obtain consent:

Signature of Patient's Next-of-Kin

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