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

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

____
Signature of Patient's Next-of-Kin

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