National University Hospital

Additional Declaration for Release of Medical Information for Patient with Mental Incapacity (Form D)

Note:
- This form is required if the applicant of "Application & Consent for Release of Medical Information" (i.e. "Form A") is the Main Caregiver of the patient who lacks capacity, as defined under the Mental Capacity Act (Cap 177A) in the absence of a Legally Appointed Representative.
- If there is more than one Main Caregiver, the declaration has to be made by each and every Main Caregiver (by signing this form separately).

Declaration

I, (name) _____ (NRIC) _____ am the (relationship to patient) _____,

and Main Caregiver of the patient (name) _____ (NRIC) _____.

Are there other Main Caregivers for the Patient?

☐ Yes (If there is more than one Main Caregiver, a declaration has to be made by each and every Main Caregiver (by signing this form separately.)

☐ No

1. I, the undersigned, hereby declare and confirm that:

   a) the Patient lacks mental capacity and is unable to make decisions about his / her personal welfare and healthcare decisions;
   b) the Patient is under my care and I am the Main Caregiver;
   c) I am not aware of any formally appointed Donee under a Lasting Power of Attorney or a Deputy by the Singapore Courts for the management of Patient's welfare; and
   d) the medical information requested is only for the purpose stated below, and not for any other purpose
      ☐ Continuity of care
      ☐ Others (please specify) _____

2. I hereby further declare that the information I have provided in this Form is true and accurate to the best of my knowledge and belief and I am validly acting on behalf of the Patient. I understand that legal action may be taken against me for any omission(s) or false statement(s) made.

3. By reason of the aforesaid, I undertake full responsibility and liability arising from the release of the medical information by National University Hospital(S) Pte. Ltd **("NUH Pte Ltd.").** and shall indemnify NUH Pte. Ltd. against any liability, demand, claims, losses and legal costs incurred due to false statements or omissions by me in procuring the medical information of the Patient.

_____

Main Caregiver's Signature
Date:

Explained by:

Signature of Staff
Name:
Date: