

SINGAPORE CIVIL DEFENCE FORCE

CONSENT FOR RELEASE OF AMBULANCE REPORT



EMERGENCY MEDICAL SERVICES BRANCH
MEDICAL DEPARTMENT
HQ SINGAPORE CIVIL DEFENCE FORCE
Civil Defence Complex
91 Ubi Avenue 4
Singapore 408827
Tel: 6 848 3553
Fax: 6 848 3566



I, _____ NRIC NO: _____
(*Name of patient / patient's parent / patient's next of kin)

hereby authorize you to furnish _____
(* Name of self / Next-of-kin / Agency)

of _____
(Address)

with an ambulance report on _____ NRIC / Hospital
(Name of patient)

Registration No: _____, who was conveyed by SCDF ambulance on _____.
(Date)

The medical report is required for the purpose (s) specified below:

* delete accordingly

I hereby declare and confirm that the information given above is accurate and true to the best of my knowledge and belief, and that the Ambulance Report is required for the purpose stated above. I understand that I may be liable for the prosecution for making a false declaration. Further, I confirm that I shall not hold SCDF responsible in any way whatsoever for the release of the Ambulance Report in the event of any loss or damage arising directly or indirectly as a result of the said report. I undertake full responsibility and liability arising from the release of the Ambulance Report.

Signature of Patient / Next of kin & Date

Relation to Patient

Contact Number

Instructions

1. This form must be fully completed and should be signed by the patient / patient's parent (if patient is below 21 years of age) / patient's next-of-kin (if patient is deceased, a copy of the death certificate must be produced).
2. This form and any relevant documentation shall be sent via postal mail.
3. Release of medical information is subjected to official approval.