

# 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.