Parkway Radiology

AUTHORISATION FOR RELEASE OF INFORMATION

(For Doctor's Use)

A - Particulars of Primary Doctor	
Name of Doctor:	Doctor's MCR:
Clinic Name:	

B - Particulars of Patient	
Name:	Date of Birth *(DD-MM-YYYY)*
MRN No.	

Consent to Data-Sharing & Use of Information

1. I authorise Parkway Radiology to release the electronic/soft copy images/reports of my patient's radiological study to following doctor:

Name of Doctor:	Doctor's MCR:
Clinic Name:	Clinic Phone No:
Clinic Address:	

2. I acknowledge that upon granting a doctor access to a patient's electronic radiology results, the patient's full radiology examination history will be made available to the doctor to allow for holistic patient management.

Signature of Primary Doctor	Date of Signature

The signatory of the Authorisation for release of information shall be:

a) The patient himself/herself if he/she is 21 years of age and above and is of sound mind.

b) The parent or lawful guardian if the patient is below 21 years of age.

c) The committee of person or estate appointed under the Mental Disorders & Treatment Act(Cap 178) in the case of a patient who is or unsound mind.