

**Letter of Authorisation for Release of Medical Information****Important Note:**

This form is required to be completed for the application of medical report from a hospital/clinic and should be completed by the patient or the patient's parent (if patient is below 21 years of age) or the patient's next-of-kin (if patient is deceased), and be duly witnessed.

Dear Sir / Mdm,

**Patient's Name**  
(“Patient”)

NRIC/ Passport No.

I hereby authorise you,

**Name of Doctor****Name of Clinic/ Hospital****Address of Clinic/ Hospital**

to provide China Life Insurance (Singapore) Pte. Ltd. (“CLIS”) with a detailed medical report on the Patient. This report is required for CLIS to process and assess my insurance application or insurance claim application.

I am aware that a photocopy of this authorisation shall be effective and valid as the original.

I confirm that the information I have provided in this form is true and correct. I also expressly authorise and consent to CLIS, its officers, employees and representatives collecting, storing, using, transferring and/or disclosing, any and all information relating to me and/or the Patient, whether in Singapore or elsewhere, for the purpose of allowing CLIS to evaluate, process, administer or manage my insurance application or insurance claim application. I understand that CLIS has a Personal Data Protection Notice, which sets out the purposes for which personal data may also be used and disclosed, and it is available at [www.chinalife.com.sg](http://www.chinalife.com.sg), which I confirm I have read and understood.

\_\_\_\_\_  
Signature\* of Patient/ Parent/ Next-of-Kin\_\_\_\_\_  
Date\_\_\_\_\_  
Name (in BLOCK LETTERS)\_\_\_\_\_  
Relationship to Patient\_\_\_\_\_  
NRIC / Passport Number\_\_\_\_\_  
Signature\* of Witness\_\_\_\_\_  
Date\_\_\_\_\_  
Name of Witness

\*Please delete accordingly