Letter of Authorisation for Collection of Prescription Refills under the Chronic Disease Management Programme (CDMP) and/or the Community Health Assist Scheme (CHAS)

With effect from 19 May 2020, in appropriate cases, CDMP/CHAS patients may authorise individuals to collect prescription refills for their chronic conditions on their behalf[1].

CDMP/CHAS patients and their authorised persons are advised to fill in this letter of authorisation, which should be presented to the clinic during collection of prescription refills. The authorised person may be requested to provide patient details (e.g. NRIC number, name, date of birth) for verification purposes.

Section A-1: For CDMP/CHAS patient's authorisation

I, _____ **[*name of CDMP/CHAS patient*]** authorise _____ **[*name of authorised person*]** to collect prescription refills for my chronic conditions on my behalf from _____ **[DD/MM/YYYY]** to _____ **[DD/MM/YYYY]**[1]. I agree that he/she will be responsible for ensuring that the medication is safely delivered to me.

Section A-2: For CDMP/CHAS patient who is below 21 years old or lacks mental capacity[2] only

I, _____ **[*name of parent/ legal guardian*[3]*/ donee/ deputy*[4] **/ *family member*[5]*]** authorise _____ **[*name of authorised person*]** to collect prescription refills for my chronic conditions on the patient's behalf on _____ **[DD/MM/YYYY]** to _____ **[DD/MM/YYYY]**. I agree that he/she will be responsible for ensuring that the medication is safely delivered to the patient.

[1] State "NIL" if there is no end date.
[2] A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) ("MCA").
[3] Lawfully appointed as a legal guardian by a court or under a will/deed.
[4] Authorised person is acting under a Lasting Power of Attorney registered under the MCA with power to act on behalf of the patient, or is appointed by the Court under the MCA to act on behalf of the Patient.
[5] Authorised person is the spouse, child, or parent of the Patient, is 21 years old and above, and does not lack capacity.

Section B: For authorised person's acknowledgement

I, _____ **[*name of authorised person*]** declare that I have been authorised by _____ **[*name of CDMP/CHAS patient*]** to collect his/her prescription refills on his/her behalf over the period specified in Section A-1/A-2 above. I agree to the following:

i. to pay the bills in relation to the prescription refills (after MediSave/CHAS subsidies have been applied) on the CDMP/CHAS patient's behalf;
ii. to check that I have collected the right medication for the CDMP/CHAS patient and safely deliver the medication to him/her; and
iii. to indemnify the CDMP/CHAS clinic and/or the Government against all losses, expenses, costs, damages and liabilities that may be suffered or incurred by the clinic/Government arising out of or in connection with any false declaration or improper conduct on my part.

Signature & NRIC No. of CDMP/CHAS Patient:

Signature & NRIC No. of authorised person: