

I. 資料當事人(病人)資料 Particulars of the Patient

閣下必須提供正確的個人資料，以便本院能適當地安排閣下所需文件。
Your personal information as listed below are necessary for proper document arrangement as requested.

英文姓名: _____ 中文姓名: _____
Name in English: _____ Name in Chinese: _____
(IN BLOCK LETTER 請以正楷大寫填寫)

性別: Male 男 Female 女 出生日期: _____
Sex: _____ Date of Birth: _____

香港身份證/其他證件號碼: _____ 醫療記錄號碼: _____
HKID/ Other Identity Document No.: _____ A-number: _____

聯絡電話: _____ 電郵: _____
Telephone No.: _____ E-mail: _____

II. 申請人(如非病人本人)資料 Particulars of the Applicant (if not patient)

英文姓名: _____ 中文姓名: _____
Name in English: _____ Name in Chinese: _____
(IN BLOCK LETTER 請以正楷大寫填寫)

香港身份證號碼: _____ 與病人關係: _____
HKID No. _____ Relationship with Patient: _____

聯絡電話: _____ 電郵: _____
Telephone No.: _____ E-mail: _____

#在向本院提交本申請表格時，請親身出示有關人士/申請人的身份證明文件正本或提交真確副本。
Please produce in person the original or provide a true copy of the identity document of the Relevant Person/Applicant when submitting this application.

申請人與病人的關係 Relationship between the Applicant and the Patient

(如果本申請乃由有關人士代表第一部份所註明的病人提出，則須寫此部分)
(To be completed if a Relevant Person Applies for Access on behalf of the Patient Referred to in Section 1)

- 請選擇 病人年齡未滿十八歲，而有關人士對病人有父母責任；
EITHER The Relevant Person has parental responsibility for the Patient who is under age 18;
或 有關人士獲病人授權提交申請，以及代其領取要求資料；
OR The Relevant Person has been duly authorized by the Patient to submit this and to collect the Requested Data on behalf of the Patient;
或 病人無能力管理本身事務，有關人士獲法院任命管理該等事務。
OR The Patient is incapable of managing his own affairs and the Relevant Person has been appointed by a court to manage those affairs.
或 病人屬<精神健康條例>(第136章)第2條所指的精神上無行為能力，而：
OR The Patient is mentally incapacitated within the meaning of section 2 of the Mental Health Ordinance (Cap.136), and:
(i) 有關人士根據該條例第44A、59O、59Q條獲委任擔任病人的監護人；或
The Relevant Person has been appointed under section 44A, 59O or 59Q of that Ordinance to be the Patient's guardian; or
(ii) 有關人士根據該條例第44B(2A)或(2B)或59T(1)或(2)條獲轉歸病人的監護，或執行病人的監護人的職能
The Relevant Person has been vested the guardianship of the Patient or the Relevant Person has to perform the functions of the appointed guardian under section 44B(2A) or (2B) or 59T(1) or (2) of that Ordinance

#請一併提供能證明申請人與病人之間關係的證件真確副本
Please also provide a true copy of the documentary evidence to support the relationship between the Applicant and the Patient.

III. 申請項目 Requested Item

期間: _____ 由: _____ 至: _____
Period: _____ From: _____ To _____

申請本院的下列資料(請在適當方格上加上√號) Information requested (Please check in the appropriate boxes)

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> 門診記錄
Outpatient Progress Note | <input type="checkbox"/> 出院撮要
Discharge Summary | <input type="checkbox"/> 住院記錄
Inpatient Progress Note | <input type="checkbox"/> 手術記錄
Operation Record | <input type="checkbox"/> 複製相片
Duplicate of Photo |
| <input type="checkbox"/> 醫療造影
Radiology Report | <input type="checkbox"/> 化驗報告
Laboratory Report | <input type="checkbox"/> X-光片/光碟/報告書
X-Ray Film/CD/Booklet | <input type="checkbox"/> 其他
Others: _____ | |
| <input type="checkbox"/> 到診記錄
Attendance Record | <input type="checkbox"/> 出生證明書
Birth Certificate | <input type="checkbox"/> 醫療報告
Medical Report | 醫生名稱:
Doctor's name: _____ | |

申請之原因 Purpose of Request

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> 日後醫療用途
for future medical purposes | <input type="checkbox"/> 法律申訴程序
for legal proceedings | <input type="checkbox"/> 申請保險賠償
for insurance claim | <input type="checkbox"/> 個人記錄
for personal reference |
| <input type="checkbox"/> 移民/簽證
Immigration/Visa | <input type="checkbox"/> 申請工傷賠償
Employee Compensation | <input type="checkbox"/> 其他
Others: _____ | |

IV. 申請方法及程序 Application Method & Procedure

1. 申請須知 Application Notes

- a) 本申請是根據個人資料(私隱)條例而進行。任何個人或代表一個人的有關人士有權提出查閱資料及資料複本要求。
This application is processed under the Personal Data (Privacy) Ordinance. An individual or a relevant person on behalf of an individual is entitled to make a Data Access Request to ascertain whether our hospital holds the personal data of the Data Subject or if our hospital holds such data, to be supplied with a copy of such data.
- b) 除獲有關個人的同意外，本表格收集的個人資料只可用於處理此項醫療記錄副本申請/醫療報告及其他與之直接有關的目的。
Except with the consent of the individual concerned, the personal data collected in the Form will be used for the purposes for processing this medical record copy/ medical report and other directly related purposes only.
- c) 申請人若非病人本人，必須取得病人簽署的同意書。申請人必須出示其身份證明文件或真確副本。
When a relevant person applies on behalf of the Data Subject, a written consent from the Data Subject must be obtained. The Relevant Person must present his/her original/true copy of the identity document.
- d) 本院只保留一般病人六年的住院及專科門診紀錄；及三年的急症室及普通科門診紀錄。
The hospital will normally keep in-patient and specialist out-patient records for 6 years and A&E and general out-patient records for 3 years.
- e) 本院並不會處理非駐院醫生的保險賠償表及醫療報告書，請自行聯絡有關醫生。
Insurance claim form and medical report for patients under the care of our visiting doctors will not be handled. Please contact the attending doctors directly.
- f) 本院提供之資料一概以英文為主，並沒有提供翻譯服務。若有任何疑問，請於辦公時間內與本院臨床資訊管理部聯絡。
All information provided by the Union Hospital is in English, no translation service is provided in our hospital. Should you require further assistance, please contact CIM Department during office hours.

2. 需要與申請表一併提交之文件副本 Copy of documents to be submitted with the application form

- a) 申請病人的個人資料
- 病人的身份證明文件；
如病人年齡未滿十八歲，請附上：
 - 其出生證明書；及
 - 其父母/監護人身份證明文件；及
 - 監護人之證明。
- b) 申請去世病人的個人資料
- 死者的身份證明文件；及
 - 死者出生證明書 (如死者年齡未滿十八歲)；及
 - 死亡證明書；及
 - 申請人的身份證明文件；及
 - 遺產認證；及
 - 申請人與死者關係的證明文件。
- a) For application for a living individual's personal information
- the Patient's identity document.
If Patient is under 18 years of age;
 - the Patient's birth certificate; and
 - identity document of the parent/guardian; and
 - documentary proof of relationship of guardianship.
- b) For application for a deceased's personal information
- the Deceased's identity document; and
 - the Deceased's birth certificate (if the deceased is under 18 years of age);
 - Death Certificate; and
 - The applicant's identity document; and
 - The probate/letter of administration (as the case maybe); and
 - Documentary evidence to support the relationship between the Applicant and the Deceased.

所有提供的文件副本只作處理本申請之用，用後將於一段合理時間內銷毀。

All copies of documents provided will be used solely for the purpose of processing this request and will be destroyed within a reasonable period of time upon the completion of this request.

3. 提交申請 Submission of Application:

申請人請填妥此表格，連同病人授權書(如適用)，郵寄/傳真/電郵/親身交到本院「臨床資訊管理部」代為辦理。

Submit the completed form with patient's consent (if applicable) to Clinic Information Management Department ("CIM") by mail/e-mail/ fax/in person.

地址：	新界沙田大圍富健街18號仁安苑三樓A室	Address:	Flat 3A, Union Court, Union Hospital, 18 Fu Kin Street, Shatin, N.T.
電話號碼：	2608 3439 或 2608 3148	Telephone:	2608 3439 or 2608 3148
傳真號碼：	2608 3155	Fax Number:	2608 3155
電郵地址：	medrec@union.org	Email:	medrec@union.org
辦公時間：	星期一至五：9:00a.m.-6:00p.m.； 星期六：9:00a.m.-1:00p.m.； 星期日及公眾假期：休息	Office Hours:	Monday to Friday: 9:00a.m.-6:00p.m.； Saturday: 9:00a.m.-1:00p.m.； Sunday & Public Holiday: Closed

本人已閱讀並明白上述內容。I have read and understood the above application method and procedures.

病人簽署： _____ 日期： _____
Signature of Patient: _____ Date: _____

若由有關人士(非病人本人)提交申請 If application by Relevant Person (not patient):

有關人士(非病人本人)簽署 (如適用)： _____ 日期： _____
Signature of Relevant Person (if applicable): _____ Date: _____

4. 收費表 Fee Schedule

- 此項服務將會酌量收取費用，詳情請參考價目表。

Services charges will incur for completing the request. Please refer to Table below for details

資料類別 Types of Data	# 收費 Charge (港幣 HKD)
1. 醫療記錄副本 Duplicate Medical Records	
• *行政費(以每個申請計算) Administration Fee (per application)	\$180
• 黑白 Black & White Copy (每頁 Per page)	\$5
• 彩色 Colour Copy (每頁 Per page)	\$10
• 複製相片 Duplicate of Photo (每張 Per photo)	\$120
2. 醫療造影副本 Duplicate Medical Imaging	
• *行政費(以每個申請計算) Administration Fee (per application)	\$180
• 底片 Film (每張 Per film)	\$110
• 光碟 CD <ul style="list-style-type: none"> 首次申請 First application (每片 Per CD) 豁免 Nil 其後申請 Subsequence application (每片 Per CD) \$200 	
• 小冊子 Booklet (每項檢查 Per Exam)	\$350
3. 醫療報告書 Medical Report	
• *行政費(以每個申請計算) Administration Fee (per application)	\$180
• 保險公司 Insurance Company (每份 Per request)	\$1200
• 其他機構 Others (每份 Per request)	醫生定價 TBC by doctor
• 物理治療報告 Physiotherapy Medical Report (每份 Per request)	\$700
4. 住院保險賠償表 Inpatient Insurance Claim Form	
• *行政費(以每個申請計算) Administration Fee (per application)	\$180
• 住院期間 During Hospitalization <ul style="list-style-type: none"> 首兩份申請 First 2 applications 豁免 Nil 其後申請 Subsequence application (每份 Per request) 醫生定價 TBC by doctor 	
• **出院後 After Discharged (每份 Per request)	\$800
5. 門診保險賠償表 Outpatient Insurance Claim Form	
• *行政費(以每個申請計算) Administration Fee (per application)	\$180
• **急症門診 EMC (每份 Per request)	\$200
• **專科門診 SOPD (每份 Per request)	醫生定價 TBC by doctor
6. 出生證明書 Birth Certificate (每份 Per request)	\$300
7. 到診記錄 Attendance Record	\$300
8. 其他資料查詢 Other Enquiry (每份 Per request)	\$300 起 up

*已收取之行政費將不獲退款 The Administration fee is non-refundable.

**會診48小時後遞交，另收取行政費 48 hours after discharged, additional administrative fee will be incurred

#本院保留權利修訂或更新上述資料，恕不作另行通知。

Union Hospital reserves the right to amend the above details at any time without prior notice.

本人已閱讀並明白上述內容。I have read and understood the above application method and procedures.

病人簽署：

Signature of Patient: _____

日期：

Date: _____

若由有關人士(非病人本人)提交申請 If application by Relevant Person (not patient):

有關人士(非病人本人)簽署 (如適用)：

Signature of Relevant Person (if applicable): _____

日期：

Date: _____

5. 付款方式 Payment Methods

- 現金或信用卡: 請在入院部繳費處付款
Cash or Credit Card: Pay at the Inpatient Cashier Counter of Union Hospital
- 支票付款: 所有支票請劃線, 並列明抬頭為「仁安醫院有限公司」
Cheque: Crossed cheque payable to the "Union Medical Centre Limited".
- 銀行轉帳: 有關轉帳號碼, 請向「臨床資訊管理部」查詢
Bank Transfer: Please contact our CIM Department for the details.

6. 處理需時 Processing Time

- 本院會在收到申請後**四十天**內向申請人作出回覆。在任何情況下, 本院必須在收到有關人士提交的足夠資料、收費及有關文件後, 才會將要求的資料發放予有關人士。
Our hospital will reply to the Relevant Person within **40 days** after receiving the request. Under no circumstance will the Requested Data be released without receiving consent from the Data Subject's authorized person and outstanding charges.
- 申請者將於申請完成後收到通知, 若被通知後**六十天**內仍未領取要求資料, 有關申請將會被**銷毀**, 事前不會另行通知。
Requestor will be informed after the application has been completed. If the data is not collected within **60 days** after being informed, the requested data will be disposed without any prior notice.

7. 拒絕申請 Refusal

本申請可能因以下原因被拒絕 The application may be refused on the following grounds:

- 所提供的資料不足 the application information is not sufficient; 或 or
- 尚未全數支付申請費用 the request charges are not paid; 或 or
- 法律允許的其他原因 other reasons as permitted by law.

V. 領取個人資料的方式 Mode of Collection

- | | |
|--|--|
| <input type="checkbox"/> 親自到取
In person | <input type="checkbox"/> 郵寄至病人於本院的登記地址 (底片及光碟除外)
Mail to the patient's registered mailing address
(Except film & CD) |
| <input type="checkbox"/> 授權第三者到取 (如選擇此方式, 請填寫授權書)
Authorized person (Please provide Authorization Letter) | <input type="checkbox"/> 電郵 (如選擇此方式, 請填寫授權書)
E-mail to patient (Please provide Authorization Letter) |

本人明白並接受以郵寄或電郵方式傳送資料或存在誤送之風險, 本人同意免除本院相關的所有責任。

I understand and accept that there is a risk of misdirection of mail or e-mail and I agree to release and discharge Union Medical Centre Limited from the associated responsibility.

VI. 聲明及簽署 Declaration and Signatures

聲明及簽署 Declaration and Signatures:

本人(病人或有關人士) 謹此聲明在本申請表格內提供的資料準確無訛。本人已閱讀及明白申請醫療記錄副本/醫療報告的程序及須知。本人明瞭及同意需先繳交所有列於收費表內適用的收費後, 才可領取要求資料。我明白倘若我未能提供所需資料或提供不準確或不完整的資料, 有可能導致我的申請被拒絕。

I, the Patient or other Relevant Person, declare that the information given in this application form is accurate. I have read and understood the matters set out in the "Information and Procedure for Request of Duplicate Medical Record/ Medical Report". I understand and agree that all applicable fees listed in the Scale of Fees have to be paid prior to the collection of the Requested Data. I understand that my application may be rejected if I cannot submit the sufficient and accurate information.

病人簽署: _____ 日期: _____
Signature of Patient: _____ Date: _____

若由有關人士(非病人本人) 提交申請 If application by Relevant Person (not patient):

有關人士(非病人本人)簽署 (如適用): _____ 日期: _____
Signature of Relevant Person (if applicable): _____ Date: _____