HOSPITAL AUTHORITY
醫院管理局

Alice Ho Miu Ling Nethersole Hospital
雅麗氏何妙齡那打素醫院

DATA CORRECTION REQUEST

Personal Information Collection Statement 收集個人資料聲明

Please read the following **BEFORE** you provide any personal data to us:
在向本院提供任何個人資料**之前**，請先閱讀以下內容：

1. Purpose of Collection 收集資料的目的

The personal data collected from this form will be used by the Hospital Authority ("HA"), including public hospitals / institutions managed by HA, for the purposes of processing and responding to this application.
醫院管理局 (下稱「醫管局」)，包括由醫管局管理的公立醫院 / 醫療機構，會把表格所收集的個人資料，作為處理及回覆本申請之用。

When you provide the personal data to us, please make sure that the data is accurate and complete. If you fail to provide us with the information required or if the information provided is inaccurate or incomplete, our ability to process your application may be affected and your application may therefore be declined.
當你提供個人資料給我們時，請確保資料準確和完整。如你未能提供所需的資料，或資料不準確或不完整，我們處理是次申請的能力或會受影響，而是次申請或因此被拒絕。

2. Disclosure of Personal Data 透露個人資料

Please also note that your personal data collected may be made available to:

- appropriate persons in the HA, for the purposes of processing and responding to your application; and
- third parties where such disclosure is permitted or required by law or is in the public interest.

請留意你的個人資料可能會提供予：

- 醫管局內的適當人士，以處理及回覆本申請之目的；及
- 在法律容許或要求的情況下或出於公共利益的情況下的第三方

We will obtain your consent before using your personal data for any other purposes.
我們將會在得到你的同意後，才使用你的個人資料作為其他目的。

3. Data Access / Correction Requests 查閱 / 改正資料要求

If you wish to access / correct your personal data held by HA, you may do so under Personal Data (Privacy) Ordinance. Please submit your request to relevant data controller during office hours at:

In-person: Admission, G/F, Block A, Alice Ho Miu Ling Nethersole Hospital, 11 Chuen On Road, Tai Po, N.T.
By Mail : Health Information & Records, Alice Ho Miu Ling Nethersole Hospital, 11 Chuen On Road, Tai Po, N.T

如果你希望根據《個人資料（私隱）條例》要求查閱 / 改正醫管局持有的你的個人資料，請在辦公時間內向有關的資料控制員遞交申請：

親臨遞交: 新界大埔全安路11號雅麗氏何妙齡那打素醫院A座地下入院處
郵寄遞交: 新界大埔全安路11號雅麗氏何妙齡那打素醫院醫療資訊及紀錄部

4. Enquiries 查詢

For enquiries concerning this application, please contact Medical Report Team of our Health Information & Records Office at 2689 3352.

有關本申請的查詢，應致電 2689 3352 聯絡本院醫療資訊及紀錄部醫療報告組。

Data Correction Request: Notes for Application

Please read **BEFORE** you complete and submit the Data Access Request Form:

Important Notes

- This application is processed under the Personal Data (Privacy) Ordinance. By a Data Correction Request (DCR), an individual or a relevant person on behalf of an individual can ask for correction of the Personal Data which the hospital has supplied pursuant to a Data Access Request (DAR) or by other means (e.g. HA Go). The Requestor should provide evidence to support the inaccuracies claimed.
- The Data Subject, in relation to personal data, must be a living individual.

Application Procedures

- Applications can be submitted via the following means:

In person	Location:	Admission (G/F, Block A)	
	Office Hours:	Monday to Friday:	9:00 a.m. to 12:00 noon & 1:00 p.m. to 5:00 p.m.
		Saturday, Sunday & Public Holiday:	Closed
By Mail	Address:	Health Information & Records, Alice Ho Miu Ling Nethersole Hospital, 11 Cheun On Road, Tai Po. N.T.	

Documents Required

- For application by Relevant Person, when submitting the Data Correction Request, the Relevant Person must:
  - (i) Produce in person the original or provide a true copy of his/her HKID Card / Passport
  - (ii) Provide true copy of the documentary evidence to support the relationship between the Relevant Person and the Data Subject, for examples:
    - A birth certificate/legal custody paper if the Relevant Person claims parental responsibility over the Data Subject
    - An original authorization form signed by the Data Subject where the Relevant Person claims to have been duly authorised by the Data Subject
    - A court document issued by a court appointing the Relevant Person to manage the affairs of the Data Subject who is incapable of managing his own affairs
    - A guardianship order issued by the Guardianship Board/court/magistrate which can show that the Relevant Person is currently appointed as the guardian of the mentally incapacitated Data Subject
    - Documentary evidence to show that the Relevant Person has been vested the guardianship or that he is authorised to perform the functions of a guardian under the relevant section of the Mental Health Ordinance
- Please specify clearly and in detail the inaccuracies claimed in the medical records.
- Please provide copy of the medical records containing the inaccuracies claimed, either supplied by the hospital pursuant to a DAR or by other means (e.g. via HA Go). Failing to provide copy of medical records could lead to statutory refusal to comply with the DCR.
- Please provide evidence to support the inaccuracies claimed.
- The Data Subject is required to sign next to any amendment made on the documents / application form.

Fees & Charges

- Data Correction Request is free of charge.

Time for Completion

- Our hospital will reply to the Relevant Person within 40 days after receiving the request.

Others

- Unless specially requested by the Relevant Person, our hospital will send out the reply by registered mail to the Correspondence Address provided.
- All calls from our hospital will show 2689 2108 in the caller display. Please note and pick up the call.

Enquiry

- Telephone No.: (+852) 2689 3352

HOSPITAL AUTHORITY
醫院管理局

Alice Ho Miu Ling Nethersole Hospital
雅麗氏何妙齡那打素醫院

DATA CORRECTION REQUEST

IMPORTANT NOTES

- Please read "Data Correction Request: Notes for Applicants" before completing the form and submitting the request.
- Except with the consent of the individual concerned, the personal data collected in this Form will be used for the purpose of processing this DCR and other directly related purposes only.
- A data user is required by the Personal Data (Privacy) Ordinance to comply with a DCR within 40 days after receiving the same. If a data user is unable to comply with the DCR within the 40-day period, it must inform the requestor by notice in writing that it is so unable and the reasons.

1. DATA USER

Name of Hospital Authority (HA) Institution from which Medical Records are required :

❑ Alice Ho Miu Ling Nethersole Hospital ❑ Other HA Institution: please complete "DCR (Additional Information)"

2. DETAILS OF DATA SUBJECT WHO MUST BE A LIVING INDIVIDUAL

Name (English) : _____ Name (Chinese) : _____

HKID Card No. : _____ / Passport No. : _____

Gender : ❑ Male ❑ Female Age : ❑ Under 18 y/o ❑18 y/o or over

Tel No. (Daytime) : _____ Tel No. (Other) : _____

Address : _____

 # If the HKID Card No. is provided, no copy or physical production of the HKID Card is required in case the number provided is accurate and corresponds to the number recorded on HA's database. If not, a true copy of the HKID Card will be required for verification. Alternatively, the HKID Card may be physically produced for verification at our hospital.

 # If the Passport No. is provided, please produce in person the original or provide a true copy of the Passport of the Data Subject when submitting this DCR to our hospital.

3. DETAILS OF INACCURACIES CLAIMED

(Please specify clearly and in detail the inaccuracies claimed and on which medical records the inaccuracies are found. Please provide information on separate sheets if the provided space is insufficient)

Medical Record Type	Date	Details of Inaccuracies	Copy Available?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

❑ Please tick and complete where appropriate

4. DETAILS OF RELEVANT PERSON

(To be completed if a Relevant Person applies on behalf of the Data Subject Referred to in Section 2)

Name (English) : _____ Name (Chinese) : _____

HKID Card No. : _____ / Passport No. : _____

Gender : ❑ Male ❑ Female Age : ❑ Under 18 y/o ❑ 18 y/o or above

Tel No. (Daytime) : _____ Tel No. (Other) : _____

Address : _____

 # Please produce in person the original or provide a true copy of the HKID Card/ Passport of the Relevant Person when submitting this DCR.

Relationship between the Relevant Person and the Data Subject, which can be (tick as appropriate):

EITHER ❑ a) The Relevant Person has parental responsibility for the Data Subject who is under age 18

OR ❑ b) The Relevant Person has been duly authorised by the Data Subject to submit this DCR and to collect the Requested Data on behalf of the Data Subject;

OR ❑ c) The Data Subject is incapable of managing his own affairs and the Relevant Person has been appointed by a court to manage the affairs of the Data Subject;

OR ❑ d) The Data Subject is mentally incapacitated within the meaning of the Mental Health Ordinance and the Relevant Person is:

- ❑ appointed as a guardian of the Data Subject by a court, magistrate or the Guardianship Board under section 44A, 59O or 59Q of the Mental Health Ordinance;
- ❑ the Director of Social Welfare who, pursuant to section 44B(2A) or 59T(1) of the Mental Health Ordinance, is vested the guardianship of the Data Subject;
- ❑ the Director of Social Welfare or a person approved by the Guardianship Board who, pursuant to section 44B(2B) or 59T(2) of the Mental Health Ordinance is authorised to perform the functions of a guardian for the Data Subject.

If the box in 5(d) is ticked, state the date when the Relevant Person was appointed a guardian/was vested the guardianship / was authorised to perform the functions of a guardian: _____

Is the appointment / vesting / authority to perform under 5(d) still subsisting? ❑ Yes ❑ No

In proof of my above capacity, I hereby enclose the true copy of the following:

❑ Birth certificate ❑ Court order ❑ Written authorisation

❑ Other (Please specify): _____

6. DECLARATION & SIGNATURE

WHERE applicable, the Data Subject has irrevocably authorised the Relevant Person to deal with this Data Correction Request (DCR) and to collect the reply and related documents on behalf of the Data Subject.

The Data Subject and (where appropriate) the Relevant Person declare that the information given in this DCR Form is accurate.

Signature of Data Subject: _____ Date: _____

If application is made by Relevant Person

Signature of Relevant Person: _____ Date: _____

❑ Please tick and complete where appropriate