PRINCE OF WALES HOSPITAL
威爾斯親王醫院

(For Office Use Only 只供有關部門填寫)
MRO/MR_____
Date: _____

醫療報告/醫療記錄及醫生證明書修正表格
MEDICAL REPORT /MEDICAL RECORDS AND MEDICAL CERTIFICATE AMENDMENT FORM

(Please read the "Notes of Application for Medical Report / Patient's Information" before completing this form)
Except with the consent of the individual concerned, the personal data collected in this Form will be used for the purpose of processing this application and other directly related purposes only.
(在填寫本表格前請先參閱"醫療報告及病人資料申請須知")
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申請及其他與之直接有關的目的。

1. PARTICULARS OF PATIENT 病人個人資料

(a) Name 姓名: (English 英文) _____ (Chinese 中文) _____

(b) Sex 性別: ☐ Male 男 ☐ Female 女 Age 年齡: _____ Date of birth 出生日期: _____

(c) HKID Card no. 香港身份證號碼: _____ OR 或 Passport no. 護照號碼: _____

(d) Address 地址: _____

(e) Daytime telephone no. 電話號碼(日間) : _____ Other contact no. 其他聯絡電話號碼: _____

2. NATURE OF AMENDMENT 修正項目 (PLEASE CHOOSE ONE ONLY 只可選擇其中一項)

(a) ☐ Medical report 醫療報告 (Reference number 參考號碼 MRO/MR _____)

(b) ☐ Medical certificate 醫生證明書

(c) ☐ Medical records 醫療記錄

3. DOCUMENTS ENCLOSED 附上文件 (PLEASE CHOOSE ONE ONLY 只可選擇其中一項)

(a) ☐ I enclose herewith the original medical report / medical certificate. 本人現附上醫療報告/醫生證明書的正本。

(b) ☐ I declare that the original medical report / medical certificate dated _____is lost and invalid.
本人現聲明於_____年_____月_____日的醫療報告/醫生證明書的正本已遺失及失效。

***(Please note 請注意:** The original medical report **will NOT** be re-issued 本院將**不會**補發醫療報告/醫生證明書的正本)*

If (a) and (b) are not applicable, please apply for a new medical report / medical certificate by using the "Medical report / medical information application form". 如 (a)及(b) 不適用, 請以"醫療報告及病人資料申請表格"申請新的醫療報告/醫生證明書。

4. DETAILS OF AMENDMENT 要求修正詳情 (Note: For doctors' reference only 請注意：以下要求只供醫生作參考用途)

_____

_____

_____

_____

5. PARTICULARS OF APPLICANT 申請人資料 (To be completed if the applicant is not the patient 如病人為申請人則此項不須填寫)

(a) Name 姓名: (English 英文) _____ (Chinese 中文) _____

(b) Sex 性別: ☐ Male 男 ☐ Female 女 HKID Card no.香港身份證號碼: _____ Tel. No.電話號碼: _____

(c) Address 地址: _____

(d) Relationship with patient 與病人關係: _____

Applicant's signature 申請人簽署: _____

Date 日期: _____

6 PATIENT'S CONSENT 病人同意 (To be completed by living patient over 18 years old 只供年滿十八歲的在生人仕填寫)

I consent to have my medical information disclosed to the applicant / concerned authority.
本人同意院方將本人之病歷資料發放給申請人/有關人仕。

Patient's signature 病人簽署: _____

Date 日期: _____

(Please ✓in the appropriate box - 請在適當方格填上✓號)
Last Updated 02/12/2021