大 埔 醫 院
TAI PO HOSPITAL

HOSPITAL AUTHORITY
醫 院 管 理 局

Tai Po Hospital
大 埔 醫 院

AMENDMENT OF MEDICAL REPORT / PATIENT'S INFORMATION: APPLICATION FORM

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 : Enquiry, G/F, Main Block, Tai Po Hospital, 9 Chuen On Road, Tai Po, N.T.
By Mail : Health Information & Record, 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 9號大埔醫院正座地下詢問處
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。

AMENDMENT OF MEDICAL REPORT / PATIENT'S INFORMATION: NOTES FOR APPLICATION

Application Procedures

- Applications can be submitted via the following means:

In person	Location:	Enquiry (G/F, Main Block)	
	Office Hours:	Monday to Friday	: 9:00 a.m. to 1:00 p.m. 2:00 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.	

- Please clearly indicate in the Part 4 of the Application Form the details of amendments requested to be made.
- Please return the original medical report / patient's information. If the original medical report / patient's information could not be return, applicant must declare in Part 3 of the Application Form that the original medical report / patient's information is lost and invalidated. If copy of medical report / patient's information is available, please provide a copy to our hospital when submitting application.
- Under no circumstances will the application for medical report / patient's information be processed without receiving consent from patient or patient's authorized person, checking original and copy of relevant documents and paying the charges.
- An authorized signature of the patient is required if there is any amendment made on the documents / application form.

Documents Required

- Consent of patient / patient's legal guardian should be obtained for an applicant to apply for amendment of the patient's medical report / patient's information.
- Consent of patient's parent / guardian should be obtained for an applicant to apply for amendment of the medical report / patient's information if the patient is under 18 years of age.
- All relevant supporting documents of the applicant, patient, and concerned parties should be presented for verification of identity upon request. Copy of the documents may be required if necessary. Examples of the supporting documents are: Hong Kong Identity Card; Marriage Certificate; Birth Certificate or Legal Custody Paper (if the patient is under 18).
- "Original consent" or "certified true copy" of the consent is required for application of amendment of medical report / patient's information.

Fees & Charges

- Amendment of Medical Report / Patient's Information is free of charge.

Time for Completion

- In general, amendment of medical report / patient's information takes approximately 8 weeks to complete.

Others

- All medical reports / patient's information are written in English.
- Please note that such amendment is subject to our doctors / hospital management's final decision.

Caller ID Display

- Calls from our Hospital will show as 1828 551 or 1828 552 on your Caller ID. Kindly answer for our call.

Enquiry

- Telephone No: (+852) 2689 3352

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AMENDMENT OF MEDICAL REPORT / PATIENT'S INFORMATION: APPLICATION FORM

1. PARTICULARS OF PATIENT

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

HKID No. : _____ / Passport No. : _____

Gender : ❑ Male ❑ Female Age : ❑ ≥18 years old ❑ <18 years old

Telephone (Daytime) : _____ Telephone (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 Patient when submitting this "Medical Report / Patient's Information Application Form" to our hospital.*

2. NATURE OF REQUEST (PLEASE CHOOSE ONE ONLY)

❑ Medical Report (Reference No.:)

❑ Patient's Information

❑ Medical Certificate ❑ Sick Leave Certificate ❑ Attendance Certificate

❑ ❑ Other (Please specify): To _____

3. DOCUMENT ENCLOSED (DOCUMENT ENCLOSED)

❑ I enclose herewith the original medical report / patient's information.

❑ I declare the original medical report / patient's information dated _____ is lost and invalid.

❑ Copy of medical report / patient's information is enclosed.

4. DETAILS OF AMENDMENT (*Note: For doctor's reference only.*)

_____

_____

_____

_____

_____

_____

_____

_____

_____

❑ Please tick and complete where appropriate

5. PARTICULARS OF APPLICANT *# MUST be completed by applicant if applicant is not patient*

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

HKID No. : _____ / Passport No. : _____

Gender : ❑ Male ❑ Female Telephone (Daytime) : _____

Address : _____

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

6. CONSENT & DECLARATION

(I) CONSENT & DECLARATION BY PATIENT (FOR ADULT PATIENT)

I irrevocably authorise the Applicant to deal with this "Application for Amendment of Medical Report / Patient's Information" and to collect the Requested Data.

I declare that the information given in this consent is true, correct and complete to the best of my knowledge, information and belief.

Signature: _____ Date: _____

(II) CONSENT & DECLARATION BY PATIENT'S FATHER / MOTHER / GUARDIAN (FOR MINOR PATIENT)

PATICULARS OF PATIENT'S FATHER / MOTHER / GUARDIAN

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

HKID No. : _____ / Passport No. : _____

Gender : ❑ Male ❑ Female Relationship : _____

Address : _____

I irrevocably authorise the Applicant to deal with this "Application for Amendment of Medical Report / Patient's Information" and to collect the Requested Data.

I declare that the information given in this consent is true, correct and complete to the best of my knowledge, information and belief.

Signature: _____ Date: _____

(III) DECLARTION BY APPLICANT

MODE OF COLLECTION

❑ I wish to receive the Medical Report / Patient's Information by registered mail.

Address: _____

❑ I wish to collect the Medical Report / Patient's Information in person. Please inform me when the Medical Report / Patient's Information is ready for collection. I understand agree that the Medical Report / Patient's Information will be sent to me by registered mail if I do not collect it within 3 months after I am informed that the Medical Report / Patient's Information is ready for collection.

I understand and agree that:

(1) If I fail to indicate the mode of collection, the Personal Data will be sent to me by registered mail.

(2) If the Personal Data sent by registered mail is undelivered and returned by the Post Office, you will dispose of it 3 months after it is returned by the Post Office without any further or prior notice to me.

Signature: _____ Date: _____

❑ Please tick and complete where appropriate