申請醫療報告/病人資料須知

1. 根據醫院管理局政策，每份醫療報告/每個專科最低收費為港幣$895，最高收費為$3,580。申請一般病人資料 (出入院日期證明、出生日期及時間、到診記錄及補發醫生證明書)，每份收費為港幣$230。

2. 申請人即使在醫療報告及病人資料發出前撤銷申請，所有已繳付之費用，概不發還。

3. 如申請醫療報告作為保險賠償用途，請附上有關表格。惟醫生可以書面形式或所提供之表格完成醫療報告。

4. 請清楚填寫申請表內的一切資料。醫療報告內容會依照該份申請表所提供的資料為準。

5. 所有醫療報告/病人資料均用英文書寫。

6. 申請人須取得病人的同意書或授權書（正本），方可申請有關病人的醫療報告及病人資料。

7. 十八歲以下病人申請醫療報告及病人資料須得病人父 / 母 / 監護人同意書（正本）。

8. 申請人、病人及有關人士等須出示有關證明文件及呈交文件副本，以核實身份，文件包括:
   - 身份證、出生證明書或法定管養權證明書（若病人在十八歲以下）

9. 如未能呈交病人/病人的授權人之同意書或出示有關證明文件正、副本及繳交費用前，有關申請將不獲處理。

10. 如經郵遞申請，請將填妥之申請表格連同劃線支票(抬頭「靈實醫院」或「醫院管理局」)付款寄回九龍將軍澳靈實路八號靈實醫院信望愛樓信翼四樓「醫療資訊及病歷檔案部」收。

11. 如在本院即時申請，請將填妥之申請表格交到本院信望愛樓望翼一樓「醫療資訊及病歷檔案處」。經核對資料後，申請人須到信望愛樓愛翼一樓會計部繳費處繳交費用。

12. 每份醫療報告需時約八星期才能完成。每份病人資料 (出入院日期證明、出生日期及時間、到診記錄及補發醫生證明書)，需時約四星期才能完成。如對報告有修正的要求，必須交回報告之正本。惟報告能否修正，將由本院及醫生作最後決定。

13. 如有任何查詢請致電本院「醫療資訊及病歷檔案部」，電話: 2703 8257 傳真: 2703 8059

Notes of Application for
Medical Report / Patient's Information

1. According to the Hospital Authority's policy, a minimum of $895 per medical report per specialty and subject to a maximum of $3,580 will be charged. $230 will be charged for requesting of patient information (Date of Admission & Discharge, Birth Date & Time, Attendance History, re-issue of Medical Certificate).

2. No refund of the charge for Medical Report and Patient's Information will be made even if the application is withdrawn before the report or/and information is/are issued.

3. If the reason for request is "Claim for Compensation / Insurance", please attach the relevant insurance form. Doctor will complete the medical report either in an essay form or in the provided form.

4. Please complete the request form clearly as the content of the medical report will be according to the **information provided in the request form.**

5. All medical reports / patient's information are written in English.

6. Consent of patient (Original) should be obtained for an applicant to apply for the patient's medical report /
patient's information.

7. Consent of patient's parent / guardian (Original) should be obtained for an applicant to apply for the medical report /
patient's information if the patient is under 18 years of age.

8. All relevant supporting documents' originals and copies of the applicant, patient and concerned parties should be presented for verification of identity upon request. The supporting documents include:
   - Identity Card, Birth Certificate or Legal Custody Paper (if the patient is under 18)

9. 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.

10. For postal applications, all cheque payment (made payable to "Haven of Hope Hospital" or "Hospital Authority") for the correct amount must be attached with your completed application form and sent to: Health Information and Records Department, 4/F, Faith Wing, Trinity Block, Haven of Hope Hospital, 8 Haven of Hope Road, Tseung Kwan O, Kowloon.

11. For requests made in-person, please submit your completed request form to Health Information and Records Service Counter on 1/F, Hope Wing, Trinity Block. After verification, applicant should settle the fee at the Accounting Department Cashier on 1/F, Love Wing, Trinity Block.

12. Each medical report will be completed in around 8 weeks. Each patient's information (i.e. Date of Admission & Discharge, Birth Date & Time, Attendance History, re-issue of Medical Certificate) will be completed in around 4 weeks. For any amendment request, please submit the original copy for medical report / patient's information. Please note that such amendment is subject to our doctors' / hospital management's final decision.

13. For further enquiry please contact the "Health Information and Records Department" at Tel: 2703 8257 Fax: 2703 8059

HOSPITAL AUTHORITY
醫院管理局
HAVEN OF HOPE HOSPITAL
靈實醫院

MEDICAL REPORT AND PATIENT INFORMATION APPLICATION FORM
醫療報告及病人資料申請表

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 REQUEST 申請項目

□ Medical Report 醫療報告

□ Medical Certificate 醫生證明書 From 由 _____To 至 _____

□ Others 其他: _____

3. INFORMATION REQUESTED 要求索取的資料

(a) Specialty 專科:

□ Geriatrics & Rehabilitation Service 老人及復康服務 □ Pulmonary Service 胸肺服務 □ Orthopaedics 骨科

□ Palliative Care Service 紓緩治療服務 □ Internal Medicine 內科 □ Infirmary Service 療養服務

□ # KEC Staff Psychological Services Clinic/ CIPS Centre 九龍東職員心理服務診所/職員緊急事故心理服務中心

 # The service is provided to HA staff only. Applicants are requested to tick the box or specify in the application letter if medical report and / or client data related to the service is / are required.
此乃職員服務，如欲申請有關醫療報告及/或病人資料，必須在適當空格加上「✓」號或在信中列明。

□ Others 其他: _____

(b) Period 期間: From 由 _____ To 至 _____

4. REASON FOR APPLICATION 申請原因

(Note: For doctor's reference only 請注意: 以下要求只供醫生作參考用途)

□ Insurance Claim 申索保險賠償
(□ Claim Form Attached 保險表格附上)

□ Employee Compensation Claims 申索工傷賠償

□ Legal Proceedings 法律申訴程序

□ Support of Application for Family Reunion
協助申請家人來港團聚

□ Rehousing Application 房屋調遷

□ Immigration / Visa Application 申請移民 / 簽證

□ Personal Record 個人記錄

□ Other – Please Specify 其他 – 請註明
_____

5. PATIENT'S SIGNATURE 病人簽署

(If the patient is the recipient of this medical report, please sign this section 如病人是本份醫療報告的接收人，請在下欄簽署)

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

□ Please tick the appropriate box 請在適當方格加上✓ 號

6. PARTICULARS OF PATIENT'S AUTHORIZED PERSON / AGENT 獲授權人士／代理人資料

For the person who has been duly authorized by the patient to submit this medical report application 此欄適用於獲病人委托或授權提交醫療報告申請

(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: _____

(c) Tel No.電話號碼: _____ Relationship with patient 與病人關係: _____

(d) Address 地址 *(If different from above 如與上址不同)* :_____

Signature of the Patient's Authorized Person / Agent：_____ Date： _____
獲授權人士 / 代理人簽署 日期

PATIENT'S CONSENT 病人同意

(To be completed if the patient is a living individual and over 18 years old 只供年滿十八歲的在生人士填寫)

I hereby consent to have my medical information disclosed to the above-named authorized person / agent.

本人同意院方將本人之病歷資料發放給上述獲授權人士 / 代理人。

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

7. PARTICULARS OF PATIENT'S PARENT / GUARDIAN 病人父 / 母 / 監護人資料

For patient who is a minor (under the age of 18) or mentally incapable 此欄適用於 (未滿十八歲) 或因精神狀況而不能處理本身事務之病人

(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: _____

(c) Tel. No.電話號碼: _____ #Relationship with patient 與病人關係: _____

(#Please provide a copy of proof document of relationship with patient, e.g. Marriage / Birth Certificate 請提供關係證明副本如：結婚證明書或出世紙)

(d) Address 地址: _____

(e) I consent to have the patient's medical information disclosed to the above-named applicant.
本人同意院方將病人之病歷資料發放給上述之申請人。

Signature of the Patient's Parent / Guardian：_____ Date： _____
病人父 / 母 / 監護人簽署 日期

PLEASE SELECT COLLECTION METHOD 請選擇資料領取方法

☐ By mail 郵寄

☐ Self-collect during #Office hour
Health Information and Records Service Counter
1/F, Hope Wing, Trinity Block, HHH
#Office Hour：Monday to Friday 8:30am - 5:00pm
Saturday 9:00am – 12:00nn
Sunday and Public Holiday closed

自行在 #辦公時間內到本院索取
靈實醫院信望愛樓望翼一樓
「醫療資訊及病歷檔案處」
#辦公時間：星期一至五早上八時半至下午五時
星期六早上九時至正午十二時
星期日及公眾假期休息

FOR OFFICIAL USE ONLY
此欄只供本院填寫

For A/C Office Use	For HIRD Use
Payment Receipt No.:	Ref. No.:
Paid Chop	Chop & Sign

Checked By: _____
☐ Patient's HKID Card / Passport Number(s) *original /copy
☐ Applicant's HKID Card / Passport Number(s) *original /copy
☐ Patient's and Applicant's document of relationship
(* Marriage / Birth Certificate) *original /copy

* Delete whichever is inappropriate
☐ Please tick the appropriate box 請在適當方格加上✓號