

KWAI CHUNG HOSPITAL 葵涌醫院

Information Sheet for Medical Report and Patient Information

申請醫療報告及病人資料須知

- (1) Please complete this application. Attach the claim form (if any) and tick the appropriate box “Completion of Form / Insurance Claim Form” in item 2 (b) on this application form. Hospital reserves the right to provide the medical report in our prescribed format or on your form provided.

請填妥本申請表。如填寫表格/保險表格，可一併附上，並在本表格第2項(b)選取“填寫表格/保險表格”一欄。醫院保留權利填報閣下遞交之表格或提供另一種合適的醫療報告以供閣下備用。

- (2) Documents to be presented or submitted together with application 與申請表一併出示或提交之文件:

- 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 the Passport No. is provided, please produce in person the original or provide a true copy of the Passport. 若提交香港身份證號碼，而提交的號碼正確及與醫管局資料庫所記錄的號碼相符，無須親身出示香港身份證正本或提交真確副本。若提交護照號碼，請親身出示護照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 individual to whom this Medical Report and Patient Information is to be sent if not the Data Subject himself. 如果此醫療報告及病人資料非由資料當事人本人接收，請親身出示接收人的身份證明文件或提交真確副本。
- If the data subject is under the age of 18, please attach a copy of the Birth Certificate, the Original or a copy of the identity document of the data subject's parent / guardian and attach a copy of documentary evidence to support the relationship with the Data Subject. 如資料當事人未滿十八歲，請附同其出生證明書副本、資料當事人父/母/監人的身份證明文件正本或副本，並附上與資料當事人關係的證明文件副本。

- (3) Charges 收費:

- A minimum of HK\$895 per Medical Report / Claim Form per specialty; subject to a maximum of HK\$3580. 每份專科醫療報告 / 填寫表格最低收費為港幣 895 元；最高收費為港幣 3580 元。
- The charge of each re-issued Sick Leave Certificate / Attendance History / Payment History is HK\$230. 每張補發的病假證明 / 到診記錄 / 收費記錄收費為港幣 230 元。

Payment can be paid by cheque or cash 以支票或現金付款:

By Cheque: Crossed Cheque payable to “HOSPITAL AUTHORITY”

支票付款: 劃線支票，抬頭人為“醫院管理局”

By Cash: Please pay at the Shroff Office at 1/F Block L, Kwai Chung Hospital.

繳付現金: 請往葵涌醫院 L 座 1 樓 繳費處

No refund of the charge will be made. 申請一經接納，所繳付之費用，概不發還。

- (4) Timing 需時: In general, each medical report application will be completed within 8 weeks. Longer processing time is required depending on individual specialty, or if multi-specialties or several claim forms are involved.

一般情況下，每份醫療報告申請會在八星期內完成。因應個別專科，或申請涉及跨專科多份醫療報告或表格，處理時間會較長。

All Medical Report / Claim Form / re-issued Medical Certificate / Attendance History / Payment History are written in English. After completion, the receipt (if applicable) will be sent by registered mail directly to the person mentioned in item 3 of this application. 所有醫療報告 / 填寫表格 / 補發的醫生證明書 / 到診記錄 / 收費記錄均用英文書寫。完成後，院方會連同收據（如適用者）以掛號郵件郵寄往本表格第3項“醫療報告及病人資料的接收人”。

- (5) The completed application form can be submitted by hand or by post 填妥申請表後，請遞交或郵寄本院:

By Hand: Health Information and Records Department, 1/F, Kwai Chung Hospital Day Recovery Centre

Monday - Friday: 9:00 am to 1:00 pm and 2:00 pm to 5:15 pm

Saturday / Sunday / Public Holiday: closed

遞交: 葵涌醫院日間復元中心 1 樓 醫療資訊及紀錄部

星期一至五: 上午 9 時至下午 1 時 及 下午 2 時至 5 時 15 分

星期六、日及公眾假期: 休息

By Post: Health Information and Records Department, 1/F, Kwai Chung Hospital Day Recovery Centre,

3-15 Kwai Chung Hospital Road, New Territories.

郵寄: 新界葵涌醫院路 3-15 號 葵涌醫院日間復元中心 1 樓 醫療資訊及紀錄部

For any enquiry, please feel free to contact 2959 8241. 如有任何查詢，請致電 2959 8241。

KWAI CHUNG HOSPITAL 葵涌醫院
Medical Report and Patient Information Application Form
醫療報告及病人資料申請表

(Please tick the appropriate box. 請在適當空格上加上✓號)

For official use only:

- | | |
|---|--|
| <input type="checkbox"/> Consent signed | <input type="checkbox"/> Parent signed |
| <input type="checkbox"/> HKID No. matched PMI | <input type="checkbox"/> HKID checked |
| <input type="checkbox"/> BC checked (<18) | <input type="checkbox"/> Parent HKID checked |
| <input type="checkbox"/> Paid by Cash | <input type="checkbox"/> Paid by cheque |

Checked by _____ Date _____

MR Ref. No.: _____

1. Details of the Data Subject 資料當事人詳情:

- (a) Name: _____ (_____)
姓名 Surname 姓氏 Forename 名字 Chinese 中文姓名
- (b) Sex: ☐ Male ☐ Female (c) Age: _____ (d) Date of Birth: _____
性別 男 女 年齡 出生日期
- (e) ☐ HKID Card No.: _____ ☐ Passport No./Other No.: _____
香港身份證號碼 護照號碼/其他號碼
- (f) Address: _____
地址
- (g) Daytime Telephone No.: _____ (h) Other Contact Telephone No.: _____
日間聯絡電話號碼 其他聯絡電話號碼

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 data subject is under the age of 18, please attach a copy of the Birth Certificate. 若提交香港身份證號碼，而提交的號碼正確及與醫管局資料庫所記錄的號碼相符，無須親身出示香港身份證正本或提交真確副本。否則，須提交香港身份證的真確副本，或親身向本院出示香港身份證正本，以供查核。如資料當事人未滿十八歲，請附同其出生證明書副本。

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 Medical Report and Patient Information Application Form to our hospital. 若提交護照號碼，請在向本院提交本醫療報告及病人資料申請表時，親身出示資料當事人的護照正本或提交真確副本。

2. Data Requested 所需索取的資料:

- (a) Type of Data and Requested Period 資料類別及要求期間:
- ☐ In Patient Records ☐ Out Patient Records ☐ Allied Health Records (please specify)
入院紀錄 門診紀錄 專職醫療紀錄 (請註明) _____
- Period 期間: from 由 _____ to 至 _____

- (b) Nature of Application 申請性質:
- | | |
|---|---|
| <input type="checkbox"/> Medical Report 醫療報告 | <input type="checkbox"/> Sick Leave Certificate 病假證明 |
| <input type="checkbox"/> Completion of Form / Insurance Claim Form
填寫表格/保險表格 | <input type="checkbox"/> First-issued 首發的 (free of charge 免費) |
| | <input type="checkbox"/> Re-issued 補發的 |
| | <input type="checkbox"/> Attendance History 到診記錄 |
| | <input type="checkbox"/> Payment History 收費記錄 |

(c) Purpose of Report 醫療報告之用途:

(i) For general purpose(s) 作為一般目的之用:

- ☐ a general medical report for 一般性質的醫事報告以供:
- ☐ future medical purposes 日後醫療用途
- ☐ others, please specify 其他(請註明) _____

- ☐ a supplementary medical report 解釋或跟進一個已發出的醫療報告
(Please attach a copy of the previous medical report, if available for ease of reference.
如有以前的醫療報告, 請附上副本以作參考)

Please specify items to be included in this supplementary medical report.
請註明此跟進醫療報告所應包括之事項

(ii) For specific purpose(s) 作為指定用途:

- ☐ insurance claim 申請保險賠償
- ☐ employee compensation claims 申索工傷賠償
- ☐ application for reimbursement / direct payment of medical expenses (for civil servant only)
申請發還 / 直接支付醫療費用 (公務員適用)
- ☐ legal proceedings 法律申訴程序
- ☐ certification of sickness / injury for 證明疾病 / 受傷以用作: _____
- ☐ certification of sickness / disability in support of 證明疾病 / 傷殘用以支持:
 - ☐ immigration application 申請移民
 - ☐ rehousing application 申請公屋徙置
 - ☐ to Immigration Department for family reunion 向人民入境事務處申請家人來港團聚
 - ☐ others (state reason) 其他(請註明理由) _____

(d) Contents 內容包括:

- ☐ nature of sickness / disability / injury 疾病或傷殘或受傷性質
- ☐ nature of operation / treatment 手術 / 治療的性質
- ☐ length of hospitalization 留院日期
- ☐ length of sick leave granted 病假期間
- ☐ an assessment of the degree of permanent disability following sickness / injury
疾病 / 受傷而引致的永久傷殘程度評估
- ☐ an assessment of whether the patient will be fit to work in the job at the time of sickness / injury
評估病人將來是否適宜恢復其在患病 / 受傷前負責的工作
- ☐ others, please specify 其他(請註明) _____

(e) Mode of Collection 領取方式:

The requested medical report / patient information would be sent to you by registered mail unless you check the following box 除非你選擇以下的領取方式，否則你所要求的醫療報告/病人資料將會以掛號郵件寄出:

- ☐ collect the requested medical report / patient information in person 親自領取醫療報告/病人資料
- ☐ others, please specify 其他(請註明) _____

3. Person to whom the Medical Report and Patient Information is to be sent 醫療報告及病人資料的接收人:

The Data Subject and / or the Data Subject's parent / guardian by signing this Form consents to the relevant HA Hospital disclosing and sending the medical report and patient information to the following person:

資料當事人及/或其父/母/監護人簽署此表格代表資料當事人及/或其父/母/監護人同意有關之醫院管理局醫院向上述人士透露及發出其醫療報告及病人資料:

Name: _____ Contact Telephone No.: _____
姓名 聯絡電話號碼

HKID Card No.: _____ OR Passport No./Other No.: _____
香港身份證號碼 或 護照號碼/其他號碼

Address: _____
地址

Please produce in person the Original or provide a true copy of the identity document of the individual to whom this Medical Report and Patient Information is to be sent if not the Data Subject himself. This does not apply if the recipient is a limited company such as an insurance company.

如果此醫療報告及病人資料非由資料當事人本人接收，請親身出示接收人的身份證明文件或提交真確副本。如若接收人為一有限公司(如保險公司)，則此欄不適用。

Signature of the Data Subject
資料當事人簽署

Date 日期: _____

Signature of Witness (if applicable)
見證人簽署 (如適用者)

Date 日期: _____

For Data Subject who is a minor (under the age of 18) or mentally incapable
(此欄適用於未滿18歲或因精神狀況而不能處理本身事務之資料當事人)

Signature of Data Subject's Parent/Guardian

資料當事人父/母/監護人簽署

Date

日期

Name in Block Letter: _____

姓名(正楷填寫)

HKID Card No.: _____

香港身份證號碼

OR

或

Passport No./Other No.: _____

護照號碼/其他號碼

Please produce the Original or provide a copy of the applicant's identity document and attach a copy of documentary evidence to support the relationship with the Data Subject.

請出示申請人的身份證明文件正本或提交副本，並附上與資料當事人關係的證明文件副本。