Application for Patient Information
病人資料申請須知

1. All patient's information is written in English. This hospital does not provide translation service.
所有病人資料是以英文書寫，本院並無提供翻譯服務。

2. Application forms can be obtained from Enquiry Office at G/F, Main Building or Rehabilitation Building, Kowloon Hospital at 147A Argyle Street, Kowloon. The duly completed application form can be returned by mail. Please state "Application for Patient Information" on the envelope.
申請表格可在九龍醫院正座或康復大樓地下詢問處索取。填妥後，可親自交回或郵寄九龍亞皆老街 147 號 A 九龍醫院收，信封面註明「申請病人資料」。

3. For easy retrieval of relevant medical record, please state clearly the Data Subject (Patient)'s Hong Kong Identity Card Number and the required information.
請正確填寫資料當事人(病人)身份証號碼及所需的資料，以便翻查記錄。

4. The applicant must produce in person the original or a true copy of his/her identity document.
申請人必須親身出示其身份証明文件或提交真確副本。

5. If the applicant is not the patient, a written consent of the patient is required and the applicant must also produce in person the original or a true copy of the patient's identity document.
申請者若非病人本人，必須取得病人簽署同意書及出示其身份証明文件或提交真確副本。

6. If the applicant is the patient's parent, authorised person or person appointed by courts in Hong Kong, please produce in person the original or provide a true copy of the documentary evidence to support the relationship.
如申請人是病人之父母，授權人或獲香港法院任命之有關人士，請出示能証明申請人與病人之間關係的証明文件或提交真確副本。

7. Applying for a Certified True Copy of Advance Medical Directive (AMD) and/or Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) Order:
申請預設醫療指示 及/或 不作心肺復甦術命令的核證副本：
   - Given the risk of losing important documents associated with postal delivery, applications should be made in-person by the patient / family / carer.
   鑑於郵寄過程中可能遺失重要文件的風險，申請人應由病人/家屬/照顧者親身遞交申請。
   - The original document will be returned to the applicant immediately after photocopying.
   正本文件在影印後會即時歸還予申請人。
   - HK$300 per document will be charged for each certified true copy of AMD / DNACPR Order.
   每份預設醫療指示 / 不作心肺復甦術命令的核證副本將收取港幣 300 元。

8. HK$300 will be charged for patient's information (Certified True Copy of Documents, Attendance Record, Certificate of Hospitalization, Statement of Accounts) (with effect on 1 January 2026). Cheque, remittance or money order shall be addressed to "Hospital Authority".
申請一般病人資料 (核證副本、出席紀錄証明、住院証明、賬户結單)，每份收費為港幣三百元。(生效日期為二零二六年一月一日) 所有支票、匯票及本票請寫明支付「醫院管理局」並加劃線。

9. No refund of the fee paid will be made even if the application is withdrawn before the patient's information is ready.
即使在病人所索取的資料發出前撤銷申請，所繳付的費用亦不會發還。

10. A reminder letter will be sent to the applicant's provided address by mail if patient's information is not collected within 6 months after being informed. If the reminder letter sent by mail is undelivered and returned by the Post Office or no reply receives, patient's information will be disposed 3 months after the reminder letter issued out by mail without any further or prior notice.
若被通知可以領取病人資料後的六個月仍未領取，催函會寄遞至申請人提供的地址。若催函因未能寄遞而被郵局退回或沒有收到任何回覆，病人資料會於催函寄遞發出三個月後銷毀，事前不會另行通知。

Office hour 辦公時間	Monday to Friday: 9:00 a.m. to 12:45 p.m. & 2:00 p.m. to 4:45 p.m. 星期一至五: 上午九時至下午十二時四十五分 及 下午二時至四時四十五分 (Saturday, Sunday & Public Holiday: Closed) (星期六、日及公眾假期休息)
Office Address 辦事處地址	Medical Records Office, 1/F, Main Building, Kowloon Hospital 147A Argyle Street, Kowloon 九龍亞皆老街147號A九龍醫院 主座一樓 醫療紀錄部
Enquiry Number 查詢電話	3129 6169

九龍中醫院聯網
Kowloon Central Cluster

PATIENT INFORMATION APPLICATION FORM
病人資料申請表

1. Particulars of Patient 病人資料

(a) Name :_____ (English) _____
姓名 Surname 姓氏 Forename 名字 (英文) Chinese 中文姓名

(b) Sex :*Male/Female Age:_____ Date of Birth: _____
性別 :*男 / 女 年齡 出生日期

(c) Nature of Identity Document and Number: _____
身份證明文件類別及號碼

(d) Address: _____
地址

(e) Daytime Telephone Number: _____
日間聯絡電話號碼

 # Please produce in person the original ID card/ID document or give a true copy of ID card/ID document for verification. Should the patient be under 18 years of age, please produce the patient's original birth certificate or attach a true copy of the patient's birth certificate.
請親身出示病人的身份證明文件之正本或附上病人的身份證明文件之真確副本。如病人年齡未滿十八歲，請出示病人之出生證明書之正本或附上其出生証明書之真確副本。

2. Nature of Application 申請性質

(a) Please tick the appropriate box
請在適當方格加上「✓」號

☐ *Medical Certificate (Sick Leave Certificate) / Attendance Certificate **
醫生證明書 / 應診證明書*

☐ Discharge Slip (Patient's Copy)
出院紙 (病人備本)

☐ Certified True Copy of AMD / DNACPR Order
核證副本 (預設醫療指示 / 不作心肺復甦術命令)
(HK$300)

☐ Certified True Copy of Documents
核證副本
(HK$300)

☐ Attendance Record (*with/without fee payment record)
出席紀錄証明(*連同 /或 不連同 已付之費用)
(HK$300)

☐ Certificate of Hospitalization
住院証明
(HK$300)

☐ Statement of Accounts 賬户結單
By ☐ Hospital Number 住院號碼 _____
按照 ☐ Period 時段
(HK$300 will be charged per hospital number / period)
(收費為每項 住院號碼 / 時段 HK$300)

(b) Period 時段: From 由 _____ to 至 _____

(c) Specialty 專科: _____

(d) Purpose (Please Specify):
用途 (請註明) _____

Mode of Collection: ☐ Collect in person ☐ Registered mail
領取方法： 親自領取 掛號信郵寄

*** 請刪去不適用者**
delete whichever is inappropriate

Kowloon Hospital
九龍醫院

** 注意事項：

首次申請醫生證明書/ 應診證明書（即病人從未獲發該申請時段之醫生證明書/ 應診證明書）無需收費。
First issuance of Medical Certificate/ Attendance Certificate (i.e. Medical Certificate/ Attendance Certificate had not been issued before for the requested period) is free of charge.

如已曾經取得醫生證明書/ 應診證明書或遺失有關文件，病人亦可考慮申請重發有關醫生證明書/ 應診證明書，收費為每張HK$300。
If the Medical Certificate/ Attendance Certificate for the requested period had already been issued or lost, patient may consider applying for re-issuance of Medical Certificate/ Attendance Certificate if necessary, which the charge will be HK$300 per certificate.

醫生證明書上的病假時段會按病人的實際情況而定，並非按照申請人意願批出。
Sick leave period indicated on Medical Certificate is granted according to the patient's condition instead of the applicant's request.

本院會在收妥上述所有文件及所需費用後，方會開始處理有關申請。
The application would only be processed once all the above documents and application fee are received by our hospital.

3. Details the Relevant Person: 有關人士詳情

(To be completed if a *Relevant Person Applies **OR** *Collect the requested information on behalf of the Patient)
(如果本申請乃由 *有關人士代表病人提出 **或** *代其領取申請資料，則須填寫此部份)
*請刪除不適用者 (Delete whichever is inappropriate)

(a) Name: _____(English) (_____)
姓名 Surname 姓氏 Forename 名字 (英文) Chinese 中文姓名

(b) Sex: ☐ Male 男 ☐ Female 女 Age: _____
性別 年齡

(c) #HKID Card No.: _____ / #Passport No.: _____
#香港身份證號碼 #護照號碼

(d) Address: _____
地址
_____

(e) Daytime Telephone Number: _____
日間聯絡電話號碼

(f) Any Other Contact Telephone Number(s): _____
其他聯絡電話號碼

 # Please produce in person the original or provide a true copy of the HKID Card/Passport of Relevant Person when submitting this Application.
 # 在向本院提交本表格時，請親身出示有關人士的香港身份證／護照正本或提交真確副本。

4. Relationship between the Relevant Person and the Patient (please tick as appropriate):
有關人士與病人的關係，請在適當方格內加 ✓ 號

(To be completed if a Relevant Person Applies for Access on behalf of the Patient)
(如果本申請乃由有關人士代表病人提出，則須填寫此部份)

EITHER 請選擇 [ ] (a) The Relevant Person has parental responsibility for the Patient who is under age 18;
病人年齡未滿十八歲，而有關人士對其有父母責任；

OR 或 [ ] (b) The Relevant Person has been duly authorised by the Patient to submit this request and to collect the medical report on behalf of the Patient;
有關人士獲病人授權提交申請，以及代其領取醫療報告；

OR 或 [ ] (c) The Patient is incapable of managing his/her own affairs and the Relevant Person has been appointed by a court to manage the affairs of the Patient ;
病人無能力管理本身事務，獲法院任命的有關人士管理此人的事務；

OR 或 [ ] (d) The Patient is mentally incapacitated within the meaning of the Mental Health Ordinance and the Relevant Person is:
病人屬《精神健康條例》所指的精神上無行為能力的人，以及有關人士為：

[ ] appointed as a guardian of the Patient by a court, magistrate or the Guardianship Board under section 44A, 59O or 59Q of the Mental Health Ordinance ;
經由法院、裁判官或監護委員會就《精神健康條例》第44A、59O或59Q 條委任為病人的監護人；

[ ] 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 Patient ;
社會福利署署長就《精神健康條例》第44B(2A)或59T(1)條獲轉歸病人的監護；

[ ] 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 authorized to perform the functions of a guardian for the Patient.
社會福利署署長或監護委員會認可的人士，根據《精神健康條例》第44B(2B)或59T(2)條獲授權執行病人的監護人的職能。

If the box in (d) is ticked, state the date when the Relevant Person was appointed a guardian / was vested the guardianship / was authorized to perform the functions of a guardian :
如選擇(d) 項，請提供有關人士被委任監護人 / 獲轉歸監護 / 獲授權執行

監護人職能的日期 ：_____

Is the appointment / vesting / authority to perform under (d) still subsisting?
上述(d) 項的委任 / 轉歸 / 授權執行是否仍然有效 ？
[ ] Yes 是 [ ] No 否

 # Please also provide a true copy of the documentary evidence to support the relationship between the Relevant Person and the Patient. The documentary evidence can be:

a. a birth certificate / legal custody paper if the Relevant Person claims parental responsibility over the Patient; or
b. an original authorization form signed by the Patient where the Relevant Person claims to have been duly authorised by the Patient; or
c. a court document issued by a court appointing the Relevant Person to manage the affairs of the Patient who is incapable of managing his/her own affairs; or
d. 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 Patient; or
e. documentary evidence to show that the Relevant Person has been vested the guardianship or that he is authorized to perform the functions of a guardian under the relevant section of the Mental Health Ordinance.

 # 請一併提供能證明有關人士與病人之間關係的證件或提交真確副本。該證件為：
a. 出生證明書／法定管養權證明書(若有關人士聲稱對病人有父母責任)；或
b. 病人簽署的授權書正本(若有關人士聲稱已獲此人的授權)；或
c. 法院簽發任命有關人士管理病人事務的法院文件 (若此人無能力管理本身事務)；或
d. 監護委員會/ 法庭/ 裁判官作出的監護令，顯示有關人士現正委任為精神上無行為能力的病人的監護人；或
e. 證明文件顯示有關人士就《精神健康條例》的相關條文獲轉歸監護或獲授權執行監護人的職能。

5. <u>Declaration and Signatures</u>: 聲明及簽署

WHERE applicable, the Patient has irrevocably authorised the Relevant Person to deal with this request and to collect the patient information on behalf of the Patient. The Patient and (where applicable) the Relevant Person declare that the information given in this Patient Information Application Form is accurate.
在適用情況下，病人已授權有關人士，准許其代表病人處理此申請及領取病人資料。病人及有關人士(如適用者) 謹此聲明在此「病人資料申請」表格內提供的資料準確無訛。

Signature of the Patient: _____
病人簽署

Date: _____
日期

<u>If application by Relevant Person: 若由有關人士提交申請</u>

Signature of Relevant Person (if applicable): _____
有關人士簽署 (如適用)

Date: _____
日期

<u>FOR OFFICIAL USE:</u>

[ ] *病人／有關人士的 *香港身份證／護照號碼 已經由 _____ [職員姓名]核對正本。
*The Patient's / The Relevant Person's *HKID Card / Passport Number(s) *has / have been checked against the original by _____ [name of staff].

[ ] *病人／有關人士的 *香港身份證／護照號碼 已經由 _____ [職員姓名] 核對其 *香港身份證／護照副本 (但未經核對正本) 。
*The Patient's / The Relevant Person's *HKID Card / Passport Number(s) *has / have been checked against the copy (original not seen) by _____ [name of staff].