Hospital Authority
North District Hospital
Data Access Request (DAR) (Medical Records)

* **Please read the "Note of Application – Data Access Request".**

* **Except with the consent of the individual concerned, the personal data collected in this Form will be used for the purpose of processing this data access request and other directly related purposes only.**

[A data user is required by the Personal Data (Privacy) Ordinance to comply with a DAR within 40 days after receiving the same. If a data user is unable to comply with the DAR within the 40-day period, it must inform the requestor by notice in writing that it is so unable and the reasons, and comply with the DAR to the extent it is able to within the same 40-day period and thereafter comply or fully comply with it as soon as practicable. When medically necessary, a patient may authorize his/her private medical practitioner to contact the Hospital Authority's responsible doctor to obtain his/her medical information.]

Official use only Ref: NDH/HIRD/DA _____ / _____ Request Date: _____ Completion Date: _____

1. Data User:

Name of Hospital Authority (HA)Institution from which Personal Data is required

❑ North District Hospital ❑ Others: _____

2. Details of Data Subject who Must be a Living Individual:

Name (English): _____ (Chinese): _____

HKID Card No.: _____ or Passport No.: _____

Sex: ❑ Male ❑ Female Age: ❑ under 18 years of age ❑ 18 years of age or over

Daytime Telephone No.: _____ Other Contact No.: _____

Address: _____

3. Details of Data Under Request:

(Further information may be required to enable us to identify and/or locate the Requested Data. Please specify clearly and in detail the Requested Data. Too general a description of the Requested Data such as "all of my personal data" may render the request being refused if we are not supplied with such information as we may reasonable require to locate the Requested Data. The information provided will be up to the date of this application)

Period: From _____ To _____

Specialty: _____

Data Requested:-

Medical Record:	❑ Hospitalization Record	❑ Discharge Summary	❑ Endoscopy Record
	❑ Out-patient Record	❑ Laboratory Result	❑ A&E Record
X-ray Film:	❑ Plain X-Ray Film / Disc	❑ Plain X-Ray Report	
	❑ C.T. Scan Film / Disc	❑ C.T. Scan Report	
	❑ M.R.I. Film / Disc	❑ M.R.I. Report	

❑ Others (*please specify*) (*Please provide information on separate sheets if the provided space is insufficient.)*

_____

_____

This is my ❑ first ❑ second ❑ third ❑_____ (*please specify*) time to apply the above data.

4. Nature of Request:

❑ **Data Enquiry Request**

The Institution will inform the Data Subject (or where appropriate, the Relevant Person) whether it holds or does not hold the Requested Data.

(Please ✓ in the appropriate box)

❑ **Copy Data Request**

The Institution will inform the Data Subject (or where appropriate, the Relevant Person) whether it holds or does not hold the Requested Data.

The Institution will provide a copy of the Requested Data to the Data Subject (or where appropriate, the Relevant Person). If only [Copy Data Request] is ticked, the request will be deemed to be both [Data Enquiry Request] and [Copy Data Request]. The fee applicable for a Copy Data Request is listed in the "Note of Application – Data Access Request".

5. Particulars of Relevant Person (Applicant): ***(To be completed if a relevant person applies on behalf of the Data Subject / patient)***

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

Name (English): _____ (Chinese): _____

Sex: ❑ Male ❑ Female HKID Card No: _____ Or Passport No.: _____

Daytime Telephone No.: _____ Other Contact No.: _____

Address: _____

Relationship between the Relevant Person and the Data Subject, which can be (tick as appropriate):

EITHER ❑ (a) The Relevant Person has parental responsibility for the Data Subject who is under age 18

OR ❑ (b) The Relevant Person has been duly authorized by the Data Subject to submit this DAR and to collect the Requested Data on behalf of the Data Subject;

OR ❑ (c) The Data Subject is incapable of managing his own affairs and the Relevant Person has been appointed by a court to manage the affairs of the Data Subject;

OR ❑ (d) The Data Subject is mentally incapacitated within the meaning of the Mental Health Ordinance and the Relevant Person is :

- ❑ appointed as a guardian of the Data Subject by a court, magistrate or the Guardianship Board under section 44A, 59O or 59Q of the Mental Health Ordinance;
- ❑ 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 Data Subject;
- ❑ 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 Data Subject.

If the box in 5(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: _____

Is the appointment / vesting / authority to perform under 5(d) still subsisting? ❑ YES ❑ NO

 # Please also provided a true copy of the documentary evidence to support the relationship between the Relevant Person and the Data Subject.
Please refer to Point 4 of "Note of Application – Data Access Request".

6. Declaration and Signature:

WHERE applicable, the Data Subject has irrevocably authorized the Relevant Person to deal with this DAR and to collect the requested Data on behalf of the Data Subject. The Data Subject and (where appropriate) the Relevant Person understand and agree that all applicable fees listed in the "Note of Application – Data Access Request" have to be paid prior to collection of the Requested Data.

The Data Subject and (where appropriate) the Relevant Person declare that the information given in this Data Access Request Application Form is accurate.

Signature of Data Subject: _____ Date: _____

If application by Relevant Person

(If applicable) Signature of Relevant Person (Applicant): _____ Date: _____

For Office Use Only				To: Finance Dept,
Applicant's ID checked	❑ Y/ ❑ N	INF	❑ Y/ ❑ N	Please charge Medical Records at $ _____
Relationship checked	❑ Y/ ❑ N	PL	❑ Y/ ❑ N	Receipt no : _____
				M(HI&R)/HIRD

(Please ✓ in the appropriate box)