PRINCE OF WALES HOSPITAL

DATA ACCESS REQUEST (DAR) FORM

(Please read the "Note of Application – Data Access Request" first)

{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.(Applicable from 1 September 2010)}

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.

Office use only Ref.: PWH/MRO/PD(P)O _____ / _____ Request date:_____ Completion date:_____

1. Data User (Name of HA Institution from which Personal Data is requested):

❑ Prince of Wales Hospital ❑ Others: _____

2. Details of the Data Subject/Patient who must be a living individual

Name (English) : _____ (Chinese) : _____

HKID card no. : _____ Or Passport no. :_____

Sex : ❑ Male ❑ Female Age: The Data Subject / Patient is: **Over or** 18 years of age ❑ **Under** 18 year of age ❑

Daytime telephone no.: _____ Any other contact number(s).: _____

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 reasonably require to locate the Requested Data. The information provided will be up to the date of this application.)

Period : From _____ To _____

Data Requested:-

Medical record: ❑ Hospitalization record ❑ Discharge Summary ❑ A&E record

❑ Out-patient record (_____Clinic) ❑ Laboratory result

Type of X-ray film/disc: ❑ Plain x-ray ❑ Plain x-ray report

❑ C.T. scan ❑ C.T. scan report

❑ M.R.I. ❑ M.R.I. report

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

_____

Reason(s) for requiring the Personal Data:-

❑ For follow up treatment / ❑ For personal reference / ❑ For Insurance Claim

❑ For legal proceedings (please specify) _____

❑ Others (please specify) _____

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

4. Nature of request

❑ **(a) Data Enquiry Request** – The Institution will inform the Data Subject/Patient (or where appropriate, the Relevant Person) whether it holds or does not hold the Requested Data.

❑ **(b) Copy Data Request** –The Institution will inform the Data Subject/Patient (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/Patient (or where appropriate, the Relevant Person). If only (b) [Copy Data Request] is ticked, the request will be deemed to be both (a) [Data Enquiry Request] and (b) [Copy Data Request]. The fee applicable for a Copy Data Request is listed in the item 7(Charges) of "Notes of Application for 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 produces the original or provides a true copy of the HKID Card / Passport of the Relevant Person when submitting this request.

Name (English) : _____ (Chinese) : _____

HKID card no. : _____ Or Passport no. :_____

Sex : ❑ Male ❑ Female

Daytime telephone no.: _____ Any other contact number(s): _____

Address : _____

Relationship with the Data Subject/Patient : _____

Signature of Relevant Person(applicant) : _____ Date: _____

6. Declaration and signature (To be completed by the living individual who is over 18 years of age)

WHERE applicable, the Data Subject/Patient has irrevocably authorized the Relevant Person to deal with this Data Access Request and to collect the Requested Data on behalf of the Data Subject/Patient. The Data Subject/Patient and (where appropriate) the Relevant Person understand and agree that all applicable fees listed in the item 7(Charges) of "Notes of Application for Data Access Request" have to be paid prior to collection of the Requested Data.

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

Signature of Data Subject/Patient : _____ Date: _____

If application is not applied by the Data Subject/Patient
(If applicable)Signature of Relevant Person(applicant): _____ Date: _____

7. Consent from Data Subject's/Patient's next of kin (To be completed if the data subject/patient is under 18 years old)

Name (English) : _____ (Chinese) : _____

HKID card no. : _____ Or Passport no. :_____

Sex : ❑ Male ❑ Female

Daytime telephone no.: _____ Any other contact number(s): _____

Address : _____

Relationship with the Data Subject/Patient :_____

I consent to have the Data Subject's/Patient's Personal Data disclosed to the Relevant Person (applicant) / concerned authority.

Signature of Data Subject's/Patient's Next of Kin :_____ Date: _____

For Office Use Only

Applicant's ID checked ❑ Y / ❑ N

Relationship checked ❑ Y / ❑ N

INF ❑ Y / ❑ N

PL ❑ Y / ❑ N

AS(AC),

Please charge Medical Records at $_____

_____

SM(DS\HI&R), PWH

(Please ✓ in the appropriate box)