



**PATIENT INFORMATION APPLICATION FORM**

**病人資料申請表格**

**Patient Name:** \_\_\_\_\_ In Chinese: \_\_\_\_\_  
病人姓名 (英文) Surname 姓氏 Forename 名字 中文姓名:

Sex:  Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
性別: 男 女 年齡: 出生日期:

Patient HKID Card/ Passport No.: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
病人身份證號碼 / 護照號碼: 聯絡電話:

Address: \_\_\_\_\_  
地址: \_\_\_\_\_

**If Applicable 如適用:**

(To be completed if the applicant is a person other than the patient 如申請人非病者本人, 填寫提供資料)

**Applicant Name:** \_\_\_\_\_ In Chinese: \_\_\_\_\_  
申請人姓名 (英文) Surname 姓氏 Forename 名字 中文姓名:

Relationship with Patient: \_\_\_\_\_ Patient Consent:  Yes  No  
申請人與病人之關係: 病人授權書: 有 沒有

Applicant HKID Card/Passport No.: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
申請人身份證號碼 / 護照號碼: 聯絡電話:

Address: \_\_\_\_\_  
地址: \_\_\_\_\_

Reason / Purpose for Application: \_\_\_\_\_  
申請原因 / 用途:

I wish to apply for / 現向貴院申請:

- Certify True Copy of Documents (Medical Certificate) 有效文件(醫生證明書) 副本證明 (HK\$230.00)
- Certify Date of Admission / Attendance / Treatment 住院 / 診症 / 治療日期證明 (HK\$230.00)
- Certify Admission / Attendance / Treatment charges 住院 / 診症 / 治療收費證明 (HK\$230.00)
- Reimbursement 發還醫療費用
- Other 其他: \_\_\_\_\_

Specialty Requested \_\_\_\_\_  
索取的專科:

Period: From \_\_\_\_\_ To \_\_\_\_\_  
時段: 由 至

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

**Declaration and Signatures 聲明及簽署:**

WHERE applicable, the Patient has irrevocably authorised the Applicant to deal with this request and to collect the completed form on behalf of the Patient. The Patient and (where applicable) the Applicant declare that the information given in this form is accurate.

在適用情況下, 病人已向申請人發出不可撤銷授權, 准許其代表病人處理本申請及領取填妥表格。病人及申請人(如適用者) 謹此聲明在本表格內提供的資料準確無訛。

Patient's Signature:

病人簽署: \_\_\_\_\_

Date 日期: \_\_\_\_\_

Applicant's Signature (if applicable):

申請人簽署 (如適用): \_\_\_\_\_

Date 日期: \_\_\_\_\_