# 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 Medical Information Registry office at Room 12, 1/F, Block E, QEH at 30 Gascoigne Road, Kowloon. The duly completed application form can be returned in person or by mail. Please state "Application for Patient Information" on the envelope.
   申請表格可在醫療資料申請辦事處（伊利沙伯醫院E座一樓十二號室）索取。填妥後，可親自交回或郵寄九龍加士居道30號伊利沙伯醫院收，信封面註明「申請病人資料」。

3. For easy retrieval of relevant medical record, please state clearly the patient's Hong Kong Identity Card Number and the required information.
   請正確填寫病人身份證號碼及所需資料，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.
   申請人若非病者本人，必須取得病人簽署同意書及出示病人之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. HK$230 will be charged for patient's information (Certify True Copy of Docuements, Certify Date of Admission/Attendance/Treatment, Certify Admission/Attendance/Treatment charges). Cheque, remittance or money order shall be addressed to "Hospital Authority".
   申請一般病人資料（有效文件(醫生證明書) 副本證明、住院/診症/治療日期證明、住院/診症/治療收費證明），每份收費為港幣$230。所有支票、匯票及本票請寫明支付「醫院管理局」並加劃線。

8. No refund of the fee paid will be made even if the application is withdrawn before the patient's information is ready.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。

9. 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。

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| Office hour<br>辦公時間 | Monday to Friday: 9am-1pm & 2pm-5:45pm<br>星期一至五:<br>上午九時至下午一時 及 下午二時至五時四十五分 | Saturday, Sunday & Public Holiday: Closed<br>星期六、日及公眾假期: 休息 | |
| Office Address<br>辦事處地址 | Medical Information Registry Office, Room 12, 1/F, Block E, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon<br>九龍加士居道 30 號 伊利沙伯醫院 E 座一樓十二號室<br>醫療資料申請辦事處 | Enquiry No.<br>查詢電話 | 3506 8435 |

伊利沙伯醫院
QUEEN ELIZABETH HOSPITAL

**MR**_____

# 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: _____