Application for Duplicate Medical Record / X-ray Film
醫療紀錄 / X-光片複本申請須知

1. All medical records are written in English. This hospital does not provide translation service.
醫療紀錄是以英文書寫，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 by mail. Please state "Application for Duplicate Medical Record / X-ray Film" 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「申請醫療紀錄 / X-光片複本」。

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)身份證號碼及所需的資料，以便翻查紀錄。

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 Data Subject (Patient), a written authorization signed by the Data Subject (Patient) is required and the applicant must also produce in person the original or a true copy of the Data Subject (Patient)'s identity document.
申請者若非資料當事人(病人)本人，必須取得資料當事人(病人)簽署授權書及出示其身份証明文件或提交真確副本。

6. If the applicant is the Data Subject (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.
如申請人是資料當事人(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資料當事人(病人)之間關係的証明文件或提交真確副本。

7. An initial processing fee of HK$100.00 will be levied, including first 10 pages. Charges for duplication of medical records exceeding 10 pages is HK$1.50 per page (with effect on 1 January 2026) and charges for duplication of X-ray film / disc is HK$300 for each copy. Cheque, remittance and money order shall be addressed to "Hospital Authority".
申請人需繳交港幣一百元初步處理費(包括十頁紙費用)，超出十頁紙的影印費為每頁港幣一元五角 (生效日期為二零二六年一月一日) ，而X-光片複本 / 光碟之每張收費為港幣三百元。 所有支票、匯票及本票，抬頭請寫明支付「醫院管理局」。

8. No refund of the initial processing fee will be made even if the application is withdrawn before the duplicate medical records / X-ray films are ready.
即使在醫療紀錄 / X-光片複本發出前撤銷申請，所繳交之初步處理費亦不會發還。

9. If the applicant failed to provide sufficient documents and information required, we will refuse to comply with the Data Access Request and refund the Processing Fee.
如申請人未能提交足夠文件及所需資料，本院將會拒絕依從有關「查閱資料要求」，而所繳交之初步處理費，將會退還給申請人。

10. When the duplicate medical records / X-ray films are prepared, the applicant will be informed to collect the duplicate copies at the Medical Information Registry Office at Room 12, 1/F, Block E, QEH. If mailing service is required, please specify in the application form.
當有關醫療紀錄 / X-光片複本準備好，院方會通知申請人到醫療資料申請辦事處(伊利沙伯醫院E座一樓十二號室)領取所需之複本。 如需郵遞服務， 請在申請時一併提出。

11. A reminder letter will be sent to the applicant's provided address by mail if the duplicate medical records / X-ray films are 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, the duplicate medical records / X-ray films will be disposed 3 months after the reminder letter issued out by mail without any further or prior notice.
若被通知可以領取有關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，有關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: 9am-1pm & 2pm-5:45pm 星期一至五: 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 星期六、日及公眾假期: 休息	
Office Address 辦事處地址	Medical Information Registry Office, Room 12, 1/F, Block E, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon 九龍加士居道 30 號 伊利沙伯醫院 E 座一樓十二號室 醫療資料申請辦事處	Enquiry No. 查詢電話	3506 8435

PDARTS _____

Kai Tak Hospital / Queen Elizabeth Hospital
啟德醫院 / 伊利沙伯醫院

DATA SUBJECT (PATIENT) DATA ACCESS / DUPLICATE MEDICAL RECORD & X-RAY FILM APPLICATION FORM
查閱資料當事人(病人)資料/醫療紀錄複本及X-光片複本申請表格

(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.]

(除獲有關個人的同意外，本表格收集的個人資料只可用於處理此項查閱資料要求及其他與之直接有關的目的。)
[資料使用者必須根據個人資料(私隱)條例的規定，在收到查閱資料要求後的40日內，依從該項要求。如資料使用者不能於40日內依從該項查閱資料要求，他必須在40日的期限內以書面通知該查閱資料要求者有關情況及原因，並在他能依從該項查閱資料要求的範圍內，依從該項查閱資料要求。他其後必須在切實可行的範圍內盡快依從或盡快完全依從該項查閱資料要求。因應私家醫生診症需要，病人可授權其私家醫生聯絡醫管局的負責醫生以取得病人的病歷資料。]

1. Data User: 資料使用者

☐ Kai Tak Hospital 啟德醫院 / ☐ Queen Elizabeth Hospital 伊利沙伯醫院

2. Particulars of Data Subject (Patient) (Must be a Living Individual):
資料當事人(病人)(必須為在生人士)詳情

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

(b) Sex: ☐ Male ☐ Female (c) Age: ☐ under 18 years of age ☐ 18 years of age or over
性別 男 女 年齡 未滿十八歲 十八歲或以上

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

(e) Address: _____
地址
_____

(f) Contact Telephone Number(s): _____
聯絡電話號碼

 # If the HKID Card No. is provided, no copy or physical production of the HKID Card is required in case the number provided is accurate and corresponds to the number recorded on HA's database. If not, a true copy of the HKID Card will be required for verification. Alternatively, the HKID Card may be physically produced for verification at our hospital. If the Passport No. is provided, please produce in person the original or provide a true copy of the Passport of the Data Subject (Patient) when submitting this Data Access Request to our hospital.

 # 若提交香港身份證號碼，而提交的號碼正確及與醫管局資料庫所紀錄的號碼相符，無須親身出示香港身份證正本或提交真確副本。否則，須提交香港身份證的真確副本，或親身向本院出示香港身份證正本，以供查核。若提交護照號碼，請向本院提交本「查閱資料要求」表格時，親身出示資料當事人(病人)的護照正本或提交真確副本。

3. <u>Data Requested</u>: 要求資料

(a) Period 期間: From 由 _____ To 至 _____
(DD日 / MM月 / YYYY年) (DD日 / MM月/ YYYY年)

(b) Specialty 專科: _____

(c) Type of Data 資料類別: (Please tick as appropriate 請在適當方格內加 [✓] 號)

☐ **Duplicate Medical Records** 醫療紀錄複本

- ☐ Accident & Emergency 急症室紀錄
- ☐ Discharge Summary 出院摘要
- ☐ In-Patient / Hospitalization Record 住院期間紀錄
- ☐ Operation / Procedure Record 手術紀錄
- ☐ Out-Patient Record 門診紀錄
- ☐ Laboratory Results 化驗報告
- ☐ Clinical Photograph 臨床拍照紀錄
- ☐ Imaging Investigation Results 影像檢查報告
- ☐ Other types of record 其他類別紀錄:

(Please specify 請列明:_____)

☐ **Duplicate X-ray / Radiological Report and Images** (in Disc format)
X光 / 影像檢查 報告及影像複本 (光碟形式發放)

Report 紙本報告	**Image Disc 影像光碟**	**Type 類別**
☐	☐	Plain X-ray X光平片
☐	☐	Computed Tomography (CT) 電腦掃描
☐	☐	Ultrasound (USG) 超聲波掃描
☐	☐	Magnetic Resonance Imaging (MRI) 磁力共振掃描
☐	☐	Positron Emission Tomography (PET) 正電子電腦斷層掃描
☐	☐	Cardiac Catherization Examination 心導管檢查
☐	☐	Other 其他: (Please specify 請列明:_____)

(d) **Purpose(s) of Request: 申請之原因** (Please tick as appropriate 請在適當方格內加 [✓] 號)

- ☐ Future Medical Purposes 日後醫療用途
- ☐ Personal Records 個人記錄
- ☐ Legal Proceedings 法律申訴程序
- ☐ Insurance Claims 保險索償
- ☐ Others 其他原因 (Please specify 請列明:_____)

(e) **Is this the first time that the Requested Data is requested?**
是否第一次要求查閱所要求的資料?

☐ YES 是 ☐ NO 否

If no, please state the number of times where such a request has previously been made.
若否，請註明以往曾提出此要求的次數

☐ 2nd 兩次 ☐ 3rd 三次 ☐ _____

(f) **Exclusions: 無關資料**

I do not require any personal data which is: 本人**不需要**下述個人資料：

☐ contained in documents which had previously been provided to the Data User by the Data Subject (e.g. letters to the Data User and / or the Relevant Person (as mentioned under Section 6 below) from the Data Subject). 載於資料當事人以前曾向資料使用者提供的文件內的個人資料(例如：資料當事人向資料使用者及 / 或有關人士(如第 6 部分所述)發出的信件)。

☐ contained in documents which had previously been provided to the Data Subject by the Data User (e.g. letters to the Data Subject and / or the Relevant Person from the Data User or documents the Data User had provided to the Data Subject and / or the Relevant Person pursuant to a previous request). 載於資料使用者以前曾向資料當事人提供的文件內的個人資料(例如：資料使用者向資料當事人及 / 或有關人士發出的信件或資料使用者應過往的要求向資料當事人及 / 或有關人士所提供的文件)。

☐ in the public domain (e.g. newspaper clippings or entries in public registers concerning the Data Subject). 屬於大眾可閱覽的資料(例如：新聞剪報上或公共登記冊內關於資料當事人的資料)。

☐ set out below (please describe as fully as possible): 以下所述(請盡量詳細描述)：

_____

_____

☐ (Please tick and complete where appropriate) (請於適當方格內加上 [✓] 號，並於適當地方填上資料)

4. Nature of Request: 要求的性質

☐ Data Enquiry Request 查閱資料要求 ☐ Copy Data Request 資料複本要求

5. If a medical report is required, please specify: 如果所要求的是一份醫療報告，請註明：

☐ this has previously been prepared / supplied: _____ , or

本院以前曾經備妥 / 提供此醫療報告：_____ ；或

☐ this has not previously been prepared / supplied. 本院從未備妥 / 提供此醫療報告。

(# If a report has not previously been prepared / supplied, this will be excluded from the Requested Data and NOT be dealt with as a request under the Personal Data (Privacy) Ordinance. A separate application for a medical report may be submitted to our hospital. Please refer to the applicable scale of charges.) (# 如果本院以前從未備妥 / 提供此醫療報告，本局將會於要求資料項目中刪除此項要求及不會根據《個人資料（私隱）條例》處理此項要求。申請醫療報告可另行向本院提出。請參考所需收費。)

6. Details of the Relevant Person: 有關人士詳情

(Please tick as appropriate 請在適當方格內加 [✓] 號)

(To be completed if a Relevant Person applies for this access on behalf of the Data Subject (Patient)) (如果本申請乃由有關人士代表資料當事人(病人)提出，則必須填寫此部份)

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

(b) Title 稱謂: ☐ Mr. 先生 ☐ Ms. 女士 ☐ Miss. 小姐

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

(d) Address 地址: _____

_____

(e) Daytime Telephone No.(s) 日間聯絡電話號碼: _____

(f) Any Other Contact No.(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 Data Access Request.

 # 向本院提交『查閱資料要求』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。

7. Relationship between the Relevant Person and the Data Subject (Patient): (please tick as appropriate)
有關人士與資料當事人(病人)的關係，請在適當方格內加 [✓] 號

EITHER 請選擇 ☐ (a) The Relevant Person has parental responsibility for the Data Subject (Patient) who is under age 18;
資料當事人(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 Data Subject (Patient) to submit this Data Access Request and to collect the Requested Data on behalf of the Data Subject (Patient);
有關人士獲資料當事人(病人)授權提交本『查閱資料要求』，以及代其領取所要求的資料；

OR 或 ☐ (c) The Data Subject (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 Data Subject (Patient);
資料當事人(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 Data Subject (Patient) is mentally incapacitated within the meaning of the Mental Health Ordinance and the Relevant Person is:
資料當事人(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 Data Subject (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條委任為資料當事人(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 Data Subject (Patient);
社會福利署署長就《精神健康條例》 第44B(2A)或59T(1)條獲轉歸資料當事人(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 authorised to perform the functions of a guardian for the Data Subject (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)條獲授權執行資料當事人(病人)的監護人的職能。

If the box in 7(d) is ticked, state the date when the Relevant Person was appointed a guardian / was vested the guardianship / was authorised to perform the functions of a guardian:
如選擇7(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：

Date 日期: _____

Is the appointment / vesting / authority to perform under 7(d) still subsisting?
上述7(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 Data Subject (Patient). The documentary evidence can be:

a. a birth certificate / legal custody paper if the Relevant Person claims parental responsibility over the Data Subject (Patient);or
b. an original authorization form signed by the Data Subject (Patient) where the Relevant Person claims to have been duly authorised by the Data Subject (Patient); or
c. a court document issued by a court appointing the Relevant Person to manage the affairs of the Data Subject (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 Data Subject (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資料當事人(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(若有關人士聲稱對資料當事人(病人)有父母責任)；或
b. 資料當事人(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資料當事人(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資料當事人(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。

8. Declaration and Signatures: 聲明及簽署

WHERE applicable, the Data Subject (Patient) has irrevocably authorised 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 Scale of Fees have to be paid prior to collection of the Requested Data.

在適用情況下，資料當事人(病人)已授權有關人士，准許其代表資料當事人(病人)處理此「查閱資料要求」及領取所要求的資料。資料當事人(病人)及有關人士（如適用者）明瞭及同意需先行繳交收費表內列明的收費後，才可領取所要求的資料。

The Data Subject (Patient) and (where applicable) the Relevant Person declare that the information given in this Data Access Request Form is accurate.
資料當事人(病人)及有關人士(如適用者) 謹此聲明在此「查閱資料要求」表格內提供的資料準確無訛。

Signature of the Data Subject (Patient): _____ Date:_____
資料當事人(病人)簽署 日期

If application by Relevant Person: 若由有關人士提交申請

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

Date: _____
日期

此欄只供醫管局填寫 *FOR OFFICIAL USE ONLY*

☐ 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 Relevant Person's *HKID Card / Passport Number(s) *has/have been checked against the original by _____ [name of staff].

☐ 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 Relevant Person's *HKID Card / Passport Number(s) *has / have been checked against the copy (original not seen) by _____ [name of staff].