



Cheshire Home, Shatin  
沙田慈氏護養院

(For Office Use Only 只供有關部門填寫)

MRO/MR \_\_\_\_\_

Date: \_\_\_\_\_

已故病人醫療記錄申請表格

DECEASED PATIENT'S MEDICAL RECORDS APPLICATION FORM

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

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申請及其他與之直接有關的目的。

1. **NAME OF INSTITUTION FROM WHICH INFORMATION IS REQUESTED** 要求提供資料的醫院/診所名稱

\_\_\_\_\_

2. **PARTICULARS OF DECEASED PATIENT** 已故病人資料

(a) Name 姓名: (English 英文) \_\_\_\_\_ (Chinese 中文) \_\_\_\_\_

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

(c) HKID Card No. 香港身份證號碼: \_\_\_\_\_ OR 或 Passport No. 護照號碼: \_\_\_\_\_

(d) Address 地址: \_\_\_\_\_

\_\_\_\_\_

3. **DETAILS OF RECORDS REQUEST** 所需記錄詳情

(a) **Must be Completed** 必須填寫 Specialty 專科部門: \_\_\_\_\_

(b) Admission Information 入院資料

Hospital Number 住院號碼: \_\_\_\_\_ Request Period 申請期間 From 由 \_\_\_\_\_ To 至 \_\_\_\_\_

Hospital Number 住院號碼: \_\_\_\_\_ Request Period 申請期間 From 由 \_\_\_\_\_ To 至 \_\_\_\_\_

4. **REASON FOR APPLICATION** 申請原因

Insurance claim 申索保險賠償  Legal proceeding 法律申訴程序用途

Employee compensation claims 申索工傷賠償

Others-Please Specify 其他-請註明 \_\_\_\_\_

\_\_\_\_\_

5. **PARTICULARS OF APPLICANT** 申請人資料

(a) Name 姓名: (English 英文) \_\_\_\_\_ (Chinese 中文) \_\_\_\_\_

(b) Sex 性別:  Male 男  Female 女 HKID Card No. 香港身份證號碼: \_\_\_\_\_ Tel. No. 電話號碼: \_\_\_\_\_

(c) Address 地址: (The hospital will send the medical records / deceased's information to the following address by "Registered Post"  
醫療記錄 / 已故病人資料將以掛號形式寄往下述地址予申請人)

\_\_\_\_\_

(d) Relationship with deceased 與已故病人關係: \_\_\_\_\_

Applicant's Signature 申請人簽署 \_\_\_\_\_

Date 日期 \_\_\_\_\_

6. **CONSENT FROM DECEASED PATIENT'S NEXT OF KIN 已故病人至親同意書**

- (a) Name 姓名: (English 英文) \_\_\_\_\_ (Chinese 中文) \_\_\_\_\_
- (b) Sex 性別:  Male 男  Female 女 HKID Card No. 香港身份證號碼: \_\_\_\_\_ Tel. No. 電話號碼: \_\_\_\_\_
- (c) Address 地址: \_\_\_\_\_
- (d) Relationship with deceased 與已故病人關係: \_\_\_\_\_

(e) **Declaration 聲明**

I, declare as follows: 本人聲明如下:

- I have applied for or I have been appointed by the Court as the personal representative or one of the personal representatives to administer the deceased's estate.  
本人已經向法院申請或已經被法庭委任為死者的唯一或其中一位遺產代理人，管理死者的遺產。
- I am entitled to be the personal representative of the Deceased or I can act for and on behalf of all persons who may be entitled to apply for the administration of the Deceased's estate.  
本人有權申請成為死者的遺產代理人或本人可作為及代表所有有權申請承辦死者的遺產的人士。

- (f) I consent to have the deceased's medical information disclosed to the applicant.  
本人同意院方將死者之病歷資料發放給申請人。

\_\_\_\_\_  
Signature of the Deceased Patient's Next of Kin 已故病人至親簽署

Date 日期 \_\_\_\_\_

**Notes of Application 申請須知**

Please provide original or a true copy of the following documents upon submission of this application form  
當繳交申請表時，請出示以下文件的正本或真確副本：

1. Deceased patient's next of kin identity document.  
已故病人至親的身份證明文件。
2. Applicant's identity document.  
申請人的身份證明文件。
3. Probate or Letter of Administration.  
遺囑認證或遺產承辦書
4. Next-of-kin's relationship proof such as Marriage Certificate, Birth Certificate (if appropriate).  
已故病人至親與病人關係的證明文件，例如結婚證明書、出生證明書(如適用)。
5. Copy of Deceased patient's identity document and Death Certificate (if appropriate)  
已故病人的身份證明文件/死者的身份證明文件及死亡證明書副本。
6. Charges - Copy Data Request  
收費-資料複本要求：

- |  |  |
|--|--|
| - Processing Fee:<br>處理費   | HK\$76 per request (inclusive of reproduction charge for not more than 10 pages and postage)<br>每次港幣\$76 (已包含不多於十頁的複製費及郵費) |
| - Reproduction charge for the 11th page and onward:<br>第十一頁及以後頁數的複製費                               | HK\$1 per page<br>每頁港幣\$1  |
| - Reproduction charge for ECG, EEG, X-ray Film / disc or photo etc.:<br>X 光片 / 光碟、相片、電腦掃描片、腦電圖等複製費 | HK\$230 per modality per disc<br>HK\$230 per film<br>每種造影 / 每張光碟港幣\$230<br>每張底片港幣\$230                                     |

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ID	<input type="checkbox"/> Applicant <b>and</b> <input type="checkbox"/> Patient	To: Shroff Office
Relationship	<input type="checkbox"/> BC <input type="checkbox"/> MC <input type="checkbox"/> DC <input type="checkbox"/> Others _____	Please charge at <b>\$76</b> (processing fee)
NOK's Consent	<input type="checkbox"/> Y / <input type="checkbox"/> N	Receipt No. _____
Original Request	<input type="checkbox"/> Y / <input type="checkbox"/> N	
Case	<input type="checkbox"/> NA <input type="checkbox"/> INF <input type="checkbox"/> PL <input type="checkbox"/> PI <input type="checkbox"/> LA	
Reproduction \$	<input type="checkbox"/> NA <input type="checkbox"/> Y \$1 x ( ) + \$230 x ( ) = \$	

\_\_\_\_\_  
MRO, SCH