

病人資料申請表格 Patient Data Request Form

(請在適當方格內畫上 ☒ 號。 Please ☒ as appropriate.)

I. 病人個人資料 (以身份證明文件所載者為準) Particulars of Patient (As stated on identification document)			
英文姓名: English Name:		中文姓名: Chinese Name:	
身份證明文件號碼 (與應診 / 入院時證件相同): Identification Document Number (same as the one for visit/ admission):		出生日期: 日 月 年 Date of Birth: Day Month Year	
中大醫院編號 CUHKMC Number:		性別 Sex: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	
聯絡資料: Contact Information:		手提 Mobile: 其他 Others: 電郵 Email:	
通訊地址: Correspondence Address:		單位 樓層 座號 Room/Flat Floor Block	
樓宇 / 大廈 Building		屋苑 Estate/ Village	
街道號數 Street No.		街道名稱 Street/ Road	
地區 District		國家 Country	
II. 要求的項目 (所需資料) Type of Data Requested (Requested Data)			
期間 (日/月/年 - 日/月/年): Period (DD/MM/YYYY - DD/MM/YYYY):			
<input type="checkbox"/> 醫療紀錄複本 Duplicate of Medical Record (<input type="checkbox"/> 黑白 Black & White <input type="checkbox"/> 彩色 Colour) <input type="checkbox"/> 門診診症紀錄 Outpatient Consultation Note <input type="checkbox"/> 手術紀錄 Operation Record <input type="checkbox"/> 出院摘要 Discharge Summary <input type="checkbox"/> 化驗報告 Laboratory Report <input type="checkbox"/> 醫療造影報告 Radiology Report <input type="checkbox"/> 其他 (請註明) Others (Please Specify): _____			
<input type="checkbox"/> X光片或影像複本 (不包括報告) Duplicate of Films or Image (no report included) (<input type="checkbox"/> 光碟 CD <input type="checkbox"/> USB) <input type="checkbox"/> 電腦掃描 C.T. Scanning <input type="checkbox"/> 磁力共振 MRI <input type="checkbox"/> 超聲波 Ultrasound <input type="checkbox"/> X光 X-Ray			
<input type="checkbox"/> 醫療報告 Medical Report / 主診醫生報告 Attending Physician Statement / 醫療問卷 Medical Questionnaire 醫生姓名 Doctor's Name: 特定內容 (如有) Specific Content (if any):			
<input type="checkbox"/> 保險賠償表 醫生姓名: Insurance Claim Form Doctor's Name:			
<input type="checkbox"/> 出生日期和時間紀錄 Birth Date & Time Record	<input type="checkbox"/> 到診紀錄 Attendance Record	<input type="checkbox"/> 免疫注射紀錄 Immunisation Record	<input type="checkbox"/> 賬單或收據複本 Duplicate of Invoice/ Receipt
<input type="checkbox"/> 其他 (請註明): Others (Please Specify):			
III. 申請原因 (只供參考用途) Reason for Request (For Reference Only)			
<input type="checkbox"/> 醫療參考 Clinical Follow-up	<input type="checkbox"/> 個人紀錄 Personal Record	<input type="checkbox"/> 保險索償 Insurance Claims	<input type="checkbox"/> 工傷索償 Employee Compensation Claims
<input type="checkbox"/> 法律申訴程序 Legal Proceedings	<input type="checkbox"/> 其他 (請註明): Others (Please Specify):		
IV. 付款方法 Payment Method			
<input type="checkbox"/> 繳費處 At Cashier <input type="checkbox"/> 銀行轉帳 Bank Transfer <input type="checkbox"/> 支票 Cheque			
V. 領取所需資料的方式 Mode of Collection of Requested Data			
<input type="checkbox"/> 親身領取 Collect in Person	<input type="checkbox"/> 郵寄 By post (掛號信 Registered mail)		
	<input type="checkbox"/> 郵寄到本表格第 I 部分提供的地址 Post to the address provided in Section I of this form <input type="checkbox"/> 郵寄到其他地址 Post to another address :		

(請在適當方格內書上 ☒ 號。 Please ☒ as appropriate.)

VI. 申請人的資料詳情 (如申請人不是病人本人) Particulars of Requestor (if Requestor is not the Patient)

(如申請人不是病人本人須填寫本 VI 部份 **Complete this section VI only if Requestor is not the Patient.**)

英文姓名 English Name:		中文姓名 Chinese Name:	身份證明文件號碼 Identification Document Number:
性別 Sex: <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female		聯絡電話 Tel. No.:	
與病人關係 Relationship with the Patient**	<input type="checkbox"/> (a) 病人年齡未滿十八歲，本人為病人的父 / 母或合法監護人。 I am a parent or legal guardian of the Patient who is under age 18		
	<input type="checkbox"/> (b) 本人獲病人授權提交本申請，以及代其領取 / 收取所需資料。 I have been duly authorised by the Patient to submit this request and to collect/ receive the Requested Data on behalf of the Patient		
	<input type="checkbox"/> (c) 病人無能力處理其本身事務，本人獲法庭委任以處理該等事務。 The Patient is incapable of managing his own affairs and I have been appointed by the court to manage those affairs.		
	<input type="checkbox"/> (d) 病人屬《精神健康條例》(第 136 章) 第 2 條所指的精神上無行為能力，而： The Patient is mentally incapacitated within the meaning of section 2 of the Mental Health Ordinance (Cap.136), and: (i) 本人根據該條例第 44A、59O 或 59Q 條獲委任擔任病人的監護人；或 I have been appointed under section 44A, 59O or 59Q of that Ordinance to be the guardian of the Patient; or (ii) 本人根據該條例第 44B(2A) 或 (2B) 或 59T(1) 或 (2) 條獲轉歸病人的監護，或執行病人的監護人的職能。 I have been vested the guardianship of the Patient or have to perform the functions of the appointed guardian under section 44B(2A) or (2B) or 59T(1) or (2) of that Ordinance.		
	<input type="checkbox"/> (e) 本人現申請有關已故病人的資料，本人與已故病人的關係： I am requesting data of a Deceased Patient. My relationship with the Deceased Patient:		

** 請提供「病人資料申請須知」所列之所須文件，以證明與病人的關係。

Please provide the supporting documents as set out in "Information Sheet for Patient Data Request" to prove the relationship with the Patient.

VII. 聲明及簽署 Declaration(s) and Signature

病人 / 申請人的聲明及簽署 Declaration and Signature by Patient/ Requestor

本人謹此聲明本人於本表格內所提供的資料準確無訛和完整，且本人已閱讀和明白「病人資料申請須知」的內容。本人明白倘若本人未能提供所需資料或任何為本申請而提供的資料不準確或不完整，本人之申請可能會被拒絕。

本人明白及同意需先繳交所有適用的申請收費及 / 或費用後，才可領取 / 收取所需資料。本人謹此解除香港中文大學醫學中心有限公司可能因依據本申請而向本人或按本人指示提供所需資料所引起的任何及所有法律責任。

I declare that the information provided by me in this Patient Data Request Form is accurate and complete and I have read and understand the contents in the "Information Sheet for Patient Data Request". I understand that if I fail to provide the information required or if any information provided for this request is inaccurate or incomplete, my request may be rejected.

I understand and agree that all applicable request fees and/ or charges have to be paid prior to collection/ receipt of the Requested Data. I hereby release CUHK Medical Centre Limited from any and all legal liability that may arise from the release of Requested Data to me or as instructed by me pursuant to this request.

申請已故病人資料之申請人的進一步聲明

Further declaration by Requestor who requests data of a Deceased Patient

本人謹此聲明 I declare that:

- ☐ 本人已經向法庭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 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。
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.

病人簽署 (十八歲或以上)
Patient's Signature (Aged 18 or above)

申請人簽署 (如適用)
Requestor's Signature (if applicable)

日期 (日-月-年)
Date (dd-mm-yyyy)