香 港 眼 科 醫 院
HONG KONG EYE HOSPITAL

Application for Medical Report
醫療報告申請須知

1. All medical reports are written in English. This hospital does not provide translation service. The format of medical report is decided by the doctor. Attached forms provided by applicant may not be applicable.
醫療報告以英文簽發，本院並無翻譯服務。報告的形式由負責撰寫醫生決定，附來表格未必適合填寫。

2. Application forms can be obtained from Enquiry Counter at Medical Records Office, G/F, Hong Kong Eye Hospital at 147K Arygle Street, Kowloon. The duly completed application form can be returned in person or by mail. Please state "Application for Medical Report" on the envelope. For enquiry, please contact us at 2762 3299 during our office hours: Monday to Friday 9:00am to 1:00pm and 2:00pm to 5:00pm (Closed on Saturday, Sunday and Public Holidays).
申請表格可在病歷檔案部詢問處（香港眼科醫院地下）索取。填妥後，可親自交回或郵寄九龍亞皆老街 147K 香港眼科醫院病歷檔案部收，信封面註明「申請醫療報告」。如有查詢，請於辦公時間內致電2762 3299 : 星期一至星期五，上午九時至下午一時及下午二時至五時 (星期六、日及公眾假期休息)。

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，以便翻查記錄。

4. If necessary, the applicant must produce in person the original or a true copy of his / her identity document.
如有需要，申請人必須親身出示其身份證明文件或提交真確副本。

5. If the applicant is not the Data Subject (Patient), a written consent of the Data Subject (Patient) is required and the applicant must also produce in person the original or a true copy of the applicant's identity document.
申請人若非資料當事人(病人)本人，必須取得資料當事人(病人)簽署同意書及出示申請人之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. A charge between HK$895 and HK$3,580 will be levied, depending on the type and number of reports required. Cheque, remittance or money order shall be addressed to "Hospital Authority".
報告之收費由港幣八百九十五元起至三千五百八十元，按所屬類別及專業而定。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 No refund of the fee paid for a medical report will be made even if the application is withdrawn before the medical report is issued.
即使在醫療報告發出前撤銷申請，所繳付的費用亦不會發還。

9. If a medical report is required on a particular date but it is unlikely that the report can be released on or before the specific date required, then the application will be rejected and the application together with remittance enclosed will be returned to the applicant.
在一般情形下，本院不可能保證醫療報告在某限期內可發出。如果申請人要求在指定日期發出醫療報告，本院可能會拒絕有關申請，而所付之費用，將退還申請人。

10. In normal circumstances, the time for completing a medical report of one specialty will be 8 weeks.
在一般情形下，本院完成一個專科的醫療報告需時約八星期。

11. When the medical report is prepared, it will be sent to the applicant by registered mail. If applicant want to collect the report in person, please specify in the application form.
當有關醫療報告準備好，本院會以掛號郵件寄出醫療報告。如要親自領取，請在申請時一併提出。

12. A reminder letter will be sent to the applicant's provided address by mail if medical report 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, medical report will be disposed 3 months after the reminder letter issued out by mail without any further or prior notice.
若被通知可以領取醫療報告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，醫療報告會於催函寄遞發出三個月後銷毀，事前不會另行通知。

MR_____

九龍中醫院聯網
Kowloon Central Cluster
Hong Kong Eye Hospital
香港眼科醫院

領取資料方式

☐ 院方掛號寄出 ☐ 親臨領取

MEDICAL REPORT APPLICATION FORM
醫療報告申請表格

Please tick the appropriate box 請在適當空格上加上 ✓ 號

1. Particulars of Patient: 病人資料

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

(a) Sex: ☐ Male ☐ Female Age: _____
性別 男 女 年齡

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

(c) Address:_____
地址

_____

(d) Daytime Telephone Number:_____
日間聯絡電話號碼

(e) Any Other Contact Telephone Number(s): _____
其他聯絡電話號碼

 # 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 Patient when submitting this medical report application 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記錄的號碼相符，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，請在向本院提交本表格時，親身出示資料當事人(病人)的護照正本或提交真確副本。

2. Information Requested: 索取的資料

(a) **Specialty:**_____
專科

(b) **Period:** From_____To _____
期間 由 至

Purpose(s) of Report: 醫療報告之用途

i) For general purpose(s):
作為一般目的之用

☐ future medical purposes
日後醫療用途

☐ others, please specify _____
其他（請註明）

_____

☐ A supplementary medical report
解釋或跟進一個已發出的醫療報告
 # Please attach a copy of the previous medical report, if available for ease of reference
#如有以前的醫療報告，請附上副本以作參考

Please specify items to be included in this supplementary medical report:
請註明此跟進醫療報告所應包括之事項

_____

_____

ii) For specific purpose(s):
作為指定用途

☐ insurance claim
申請保險賠償

☐ employee compensation claims
申索工傷賠償

☐ legal proceedings
法律申訴程序

☐ certification of sickness / injury for:
證明疾病 / 受傷以用作

_____

☐ certification of sickness / disability in support of :
證明疾病 / 傷殘用以支持

- ☐ immigration application
  申請移民
- ☐ rehousing application
  申請公屋徙置
- ☐ to Immigration Department for family reunion
  向入境事務處申請家人來港團聚
- ☐ others (state reason)_____
  其他（請列明理由）

  _____

(c) Contents: 內容包括

☐ nature of sickness / disability / injury
疾病或傷殘或受傷性質

☐ nature of operation / treatment
手術 / 治療的性質

☐ length of hospitalization
留院日期

☐ length of sick leave granted
病假日期

☐ others, please specify _____
其他（請註明）

_____

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

(To be completed if a Relevant Person applies on behalf of the Patient)
（如果本申請乃由有關人士代表病人提出，則須填寫此部份）

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

(b) Sex: ☐ Male 男 ☐ Female 女 Age: _____
性別 年齡

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

(d) Address:_____
地址

(e) Daytime Telephone Number:_____
日間聯絡電話號碼

(f) Any Other Contact Telephone Number(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 request.

 # 在向本院提交本表格時，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。

4. **Relationship between the Relevant Person and the Patient (please tick as appropriate):**
有關人士與病人的關係, 請在適當方格內加 ✓號

EITHER 請選擇 [ ] (a) The Relevant Person has parental responsibility for the Patient who is under age 18;
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 Patient to submit this request and to collect the medical report on behalf of the Patient;
有關人士獲病人授權提交申請，以及代其領取醫療報告；

OR 或 [ ] (c) The 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 Patient ;
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 Patient is mentally incapacitated within the meaning of the Mental Health Ordinance and the Relevant Person is appointed as a guardian of the Patient by a court, magistrate or the Guardianship Board under the relevant section of the Mental Health Ordinance.
病人屬《精神健康條例》所指的精神上無行為能力的人，以及有關人士經由法院、裁判官或監護委員會就《精神健康條例》的相關條文，獲委任為病人的監護人。

 # Please also provide a true copy of the documentary evidence to support the relationship between the Relevant Person and the Patient. The documentary evidence can be:

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

5. Declaration and Signatures: 聲明及簽署

WHERE applicable, the Patient has irrevocably authorised the Relevant Person to deal with this medical report request and to collect the medical report on behalf of the Patient. The Patient and (where applicable) the Relevant Person declare that the information given in this Medical Report Request Form is accurate.
在適用情況下，病人已授權有關人士，准許其代表病人處理此醫療報告申請及領取醫療報告。病人及有關人士（如適用者）謹此聲明在此「查閱資料申請」表格內提供的資料準確無訛。

Signature of the Patient: _____
病人簽署

Date: _____
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

FOR OFFICIAL USE: 此欄只供醫管局填寫

Application Received By: _____ Date: _____

Patient ID / Passport: ☐ Match with PMI ☐ Original / True copy verified

Applicant ID / Passport: ☐ Original / True copy verified

Birth certificate: ☐ Original / True copy verified

Other Doc: _____ ☐ Original / True copy verified