香 港 眼 科 醫 院
HONG KONG EYE HOSPITAL

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

1. All medical records are written in English. This hospital does not provide translation service.
醫療記錄是以英文書寫，本院並無提供翻譯服務。

2. Application forms can be obtained from Enquiry Counter at Medical Records Office, G/F, Hong Kong Eye Hospital at 147K Argyle Street, Kowloon. The duly completed application form can be returned by mail. Please state "Application for Duplicate Medical Record / X-ray Film" 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「申請醫療記錄 / X-光片複本」。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証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. An initial processing fee of HK$76.00 will be levied, including first 10 pages. Charges for duplication of medical records exceeding 10 pages is HK$1.00 per page (with effect on 18 June 2017) and charges for duplication of X-ray film / disc is HK$230 for each copy. Cheque, remittance and money order shall be addressed to "Hospital Authority".
申請人需繳交港幣七十六元初步處理費（包括十頁紙費用），超出十頁紙的影印費為港幣一元一頁（生效日期為二零一七年六月十八日），而X-光片複本／光碟之每張收費為港幣二百三十元。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 No refund of the initial processing fee will be made even if the application is withdrawn before the duplicate medical records / X- ray films are ready.
即使在醫療記錄 / X-光片複本發出前撤銷申請，所繳付之初步處理費亦不會發還。

9. If the applicant failed to provide sufficient documents, 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，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, they will be sent to the applicant by registered mail. If the applicant wants to collect the duplicate medical records / X-ray films in person, please specify in the application form.
當有關醫療記錄 / X-光片複本準備好，本院會以掛號郵件送達申請人。如要親自領取，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。

PDARTS _____

九龍中醫院聯網
Kowloon Central Cluster

領取資料方式
☐ 院方掛號寄出 ☐ 親臨領取

Hong Kong Eye Hospital
香港眼科醫院

DATA SUBJECT (PATIENT) DATA ACCESS / DUPLICATE MEDICAL RECORD & X-RAY FILM APPLICATION FORM
查閱資料當事人（病 人）資料 / 醫療記錄複本及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 (DAR) 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. Particulars of Data Subject (Patient) who 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 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

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

(d) Address 地址: _____

_____

(e) 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 DAR 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。

2. <u>Data Requested</u>: 查閱所需資料

(a) Types of Data: [ ] Duplicate Medical Record [ ] Duplicate X-ray Film / CD [ ] Others
資料類別 醫療記錄複本 X光片複本 其他

(b) Specialty: _____
專科

(c) Period: From _____ To _____
期間 由 至

Others, please specify 其他 (請註明） _____

_____

(d) Purpose(s) of Request: 申請之原因

(1) [ ] For future medical purposes 日後醫療用途

(2) [ ] For personal reference 個人記錄

(3) [ ] For legal proceedings 法律申訴程序

(4) [ ] Others, please specify 其他 (請註明） _____

(e) Types of X-ray Film(s): X-光片類別

(1) [ ] Plain X-ray 普通 X-光片照射

(2) [ ] C.T. Scan 電腦掃描

(3) [ ] M.R.I. 磁力共振

(4) [ ] Others, please specify 其他 (請註明） _____

3. <u>Is this the first time that the Requested Data is requested?</u>
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 [ ] _____

4. <u>Nature of Request</u>: 要求的性質

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

5. <u>Details of the Relevant Person</u>: 有關人士詳情

(To be completed if a Relevant Person applies for 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 [ ] Female
性別 男 女

(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 DAR.
 # 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。

6. <u>Relationship between the Relevant Person and the Data Subject (Patient)</u> (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 DAR 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 appointed as a guardian of the Data Subject (Patient) by a court, magistrate or the Guardianship Board under the relevant section of the Mental Health Ordinance.
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，獲委任為資料當事人（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 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。

7. Declaration and Signatures: 聲明及簽署

WHERE applicable, the Data Subject (Patient) has irrevocably authorised the Relevant Person to deal with this DAR 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 DAR 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) :_____ Date: _____
有關人士簽署（如適用） 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