基督教聯合醫院
UNITED CHRISTIAN HOSPITAL

醫院管理局
HOSPITAL AUTHORITY

Medical Report and Patient Information Application Form

1. Patient Particulars *(must be completed)*

Name: _____ (_____)
(Surname) (Forename) (Chinese)

Sex: ☐ Male ☐ Female Date of Birth :_____

HKID Card No. / Passport No.: _____

Address : _____

Correspondence Address: _____
(if different from above)

Daytime Telephone No.: _____ Other contact phone number(s): _____

2. Nature of Request (Please choose one only)

☐	Medical Report	$895(Per specialty)	☐	Medical Certificate (Sick leave Certificate)	(from _____to _____) $230
☐	Birth date and time	$230	☐	Attendance Certificate	(from _____to _____) $230
☐	Death date and time	$230	☐	Attendance History	(from _____to _____) $230
☐	Others (please specify): _____		☐	Payment History	(from _____to _____) $230

3. Information Required

a) Specialty

☐ Accident & Emergency ☐ Orthopaedics ☐ Surgery ☐ Medicine & Geriatrics ☐ Paediatrics
☐ Obstetric & Gynaecology ☐ Neurosurgery ☐ Psychiatry ☐ Ear, Nose & Throat
☐ Eye ☐ Integrated Clinic ☐ General Out-Patient Clinic (please specify which clinic)_____
☐ KEC Staff Psychological Services Clinic/ CIPS Centre#
 # The service is provided to HA staff only. Applicants are requested to check the box or specify in the application letter if medical report and/or client data related to the service is/are required.
☐ Others (please specify): _____

b) Hospitalization / Request period: From _____ to _____

c) Date of Injury: _____(if appropriate)

4. Reason for application

☐ Insurance Claim (☐ with insurance claim form)
☐ Employee Compensation Claims
☐ Legal Proceedings
☐ Family Reunion
☐ Rehousing Application
☐ Application Migration / Visa
☐ Personal Records
☐ Others (please specify) :_____

5. Patient's signature ***(If the patient is the recipient of this medical report, please sign this section)***

Signature: _____ Date: _____

☐ Please √ in the appropriate box

6. Patient's Authorized Person / Agent
(If the recipient of this medical report is NOT the patient, please complete section 6 and 7)

(a) Name: _____ (_____)
(Surname) (Forename) (Chinese)

(b) Sex: ☐ Male ☐ Female HKID Card No. / Passport No.: _____

(c) Contact Telephone No: _____

(e) Address : _____

(f) Correspondence Address: _____
(if different from above)

Patient's Authorized Person / Agent Signature: _____ Date: _____

7. Patient's consent for Authorized Person / Agent ***(For patient aged 18 or above)***

I, _____(Patient's Name), HKID No: _____hereby consent to the Hospital to release my clinical data to the above-named authorized person / agent.

Patient Signature: _____ Date: _____

8.* Consent from Patient's / Deceased's next of kin** ***(To be completed if *(1) Patient aged below 18, (2) Mentally incapacitated and unable to give consent, (3) Patient has passed away.)

(a) Name: _____ (_____)
(Surname) (Forename) (Chinese)

(b) Sex: ☐ Male ☐ Female HKID Card No./Passport No.: _____

(c) Contact Telephone No: _____

(d) Correspondence Address: _____

(e) Relationship with patient /deceased: _____
(Please provide a copy of proof document of relationship with patient, e.g. Marriage / Birth Certificate)

Declaration ***(To be completed if apply for Deceased's medical report)***

I, the Applicant, declare as follows:

☐ 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.

☐ 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.

Signature of the Patient's / Deceased's next of kin: _____ Date: _____

Data Collection Method:

☐ By Mail
☐ Self-collect during office hour

FOR OFFICIAL USE ONLY

The Data Subject's and Relevant Person's *HKID Card /Passport Number(s) has been checked against the*original /copy by _____ (Name of Staff).

* Delete whichever is inappropriate
☐ Please √ in the appropriate box

Hospital Authority

United Christian Hospital

Note of Application for Medical Report / Patient's Information

1. According to the Hospital Authority's policy, a minimum of $895 per medical report per specialty and subject to a maximum of $3,580 will be charged. $230 will be charged for requesting of patient information (Proof of Date of Death, Date of Admission & Discharge, Birth Date & Time, Attendance History, Payment History, re-issue of Medical Certificate).

2. Under normal circumstances, no reimbursement will be made for cancelled requests.

3. If the reason for request is "Claim for Compensation / Insurance", please attach the relevant insurance form. Doctor will complete the medical report either in an essay form or in the provided form.

4. Please complete the request form clearly as the content of the medical report will be according to the information provided in the request form.

5. All medical reports / patient's information are written in English.

6. Consent of patient (Original) should be obtained for an applicant (a third party) to apply for the patient's medical report / patient's information.

7. Consent of patient's parent / guardian (Original) should be obtained for an applicant to apply for the medical report / patient's information if the patient is under 18 years of age.

8. Consent of patient's personal representative (Original) should be obtained for an applicant to apply for the medical report / patient's information if the patient is a deceased.

9. All relevant supporting documents of the applicant, patient and concerned parties should be presented for verification of identity upon request. Copy of the documents may be required if necessary. Examples of the supporting documents are:
   - Birth Certificate or Legal Custody Paper (if the patient is under 18)
   - Death Certificate Probate or Letter of Administration (if the patient is deceased)

10. Under no circumstances will the application for medical report / patient's information be processed without receiving consent from patient or patient's authorized person, checking original and copy of relevant documents and paying the charges.

11. For application by post, please send the duly completed application form together with a crossed cheque (made payable to "United Christian Hospital" or "Hospital Authority") of the processing fee to Data Controller Office, Level B1, Block S, United Christian Hospital, 130 Hip Wo Street, Kwun Tong, Kowloon.

12. For requests made in-person, please submit your completed application form to Data Controller Office at Level B1, Block S (next to Admission Office). Afterwards, the applicant will be asked to settle the fee at the Shroff Office (near Pharmacy), G/F Block S and present the receipt to Data Controller Office. Payment by cheque should be crossed and made payable to 'United Christian Hospital' or 'Hospital Authority'.

13. Each medical report will be completed in about 8 weeks.
    Each patient's information (i.e. proof of Date of Death, Date of Admission & Discharge, Birth Date & Time, Attendance History, Payment History, re-issue of Medical Certificate) will be completed in about 4 weeks. For any amendment request, please submit the original copy of the medical report / patient's information. Please note that such amendment is subject to our doctors / hospital management's final decision.

14. For further enquiry please call our hospital hotline 2379 9611 / 3949 4070.