鏡湖醫院
KIANG WU HOSPITAL

申請單編號：　　組號：

AUTHORIZATION FOR COLLECTION OF MEDICAL RECORDS

Patient's Name:　　**Record No.:**

Type of Applicant(Please tick in the box as appropriate)**:**

1. □Patient(Aged 18 or above)
2. Representative of Patient:
   - □Parent / Guardian of the minor
   - □Authorized person of patient with disturbance of consciousness or no capacity
   - □Legal heir of the deceased

I (applicant)_____, holder of_____（Type of ID）/_____（ID No.）hereby authorize Mr./Ms._____, holder of_____（Type of ID）/_____（ID No.）to collect my / my child's medical certificate / insurance certificate / duplicate medical records on my behalf.

I,(authorized person) who has been authorized by the applicant authentically to collect his or her / his or her child's medical certificate / insurance certificate / duplicate medical records. I,(authorized person)will be legally responsible for any fraud and compensate for all losses of Kiang Wu Hospital caused.

Applicant's Signature:_____，ID No.: _____

Authorized Person's Signature:_____，ID No.: _____

The relationship of applicant and authorized person: _____

Date:_____

※Documents to be prepared:

In order to protect the personal privacy of the patient, we will not accept the application if the following identity documents have not been prepared. Thanks for your cooperation. The authorized person should avoid any accidental or illegal damage, accidental loss, unauthorized alteration, dissemination or access of the patient's data.

a. Original and duplicate ID of applicant and patient
b. Original and duplicate ID of authorized person
c. Receipt