Please complete this form and return to one of the location below with supporting documents and payment 請填妥此表格及連同所須文件及款項交到以下其中一個地方**:**

(Please ✓ the appropriate box **請在適當方格上填上 ✓ 號**)

NB: Please allow at least 5 working days for the administrative process.

註: 處理申請文件需最少五個工作日。

For Hospital Use Only	
Reference Number	
Hospital Number	
Account Number	

☐ **Medical Records Office, Matilda International Hospital 明德國際醫院病歷紀錄部**
41 Mount Kellett Road, The Peak, Hong Kong 香港山頂加列山道 41 號
Enquiry 查詢電話：2849 0481 Fax 傳真號碼：2849 5175 Email 查詢電郵：medicalrecords@matilda.org

☐ **Matilda Medical Centre (Central) 明德醫療中心 (中環)**
3/F, Prosperity Tower, 39 Queens Road Central, Hong Kong 香港中環皇后大道中 39 號豐盛創建大廈 3 樓
Enquiry 查詢電話: 2537 8500 Fax 傳真號碼: 2537 8509 Email 查詢電郵: mmc@matilda.org

PART I: Applicant's Section
第一部份：申請人資料

(a) Name of Applicant **申請人**姓名: (English 英文) _____ (Chinese 中文) _____

(b) Sex 性別: ☐ Male 男 ☐ Female 女 HKID/Passport No. 香港身份證/護照號碼: _____

(c) Address **地址**: _____

(d) Contact No: **電話號碼**: _____ Email **電郵地址**: _____

PART II: I would like to request a copy of the following medical records of:
第二部份：現索取以下病歷紀錄乙份:

☐ Myself 本人, (Date of Birth 出生日期: _____) **or 或**;

 # Please provide a copy of HKID / Passport 請提供香港身份證或護照副本

☐ Patient aged below 18 未滿 18 歲之病人, **or 或**;

(a) Name 姓名: (English 英文) _____ (Chinese 中文) _____

(b) Sex 性別: ☐ Male 男 ☐ Female 女 Date of Birth 出生日期: _____HKID/Passport No. 香港身份證/護照號碼: _____

(c) Relationship with patient (與病人關係) : _____

 # Please provide Birth Certificate or patient or other documents proofing the identity as legal guardian, and a copy of HKID / Passport of patient's parents or legal guardian 請提供病人出生證明書副本或其他法律文件以證明合法監護人之份身份，及病人父/母/合法監護人之身份證明文件副本

☐ Deceased patient **已故病人**

(a) Name 姓名: (English 英文) _____ (Chinese 中文) _____

(b) Sex 性別: ☐ Male 男 ☐ Female 女 Date of Birth 出生日期: _____HKID/Passport No. 香港身份證/護照號碼: _____

(c) Relationship with Deceased Patient **與已故病人**之關係: _____

 # Please produce the original or provide a true copy of identity document of the Deceased's Nest-of-kin.
請出示死者近親身份證明文件或提交真確副本。

 # Please also attach a true copy of the documentary evidence to support the relationship between the Deceased and the Deceased's Next-of-kin. 請一併附上証明死者與死者近親之間關係的證件真確副本。

(d) **Declaration 聲明**

I, the Applicant, declare as follows: 本人聲明名如下:

☐ I have applied for or I have been appointed by Court as the personal representative or one of the personal representatives to administer the deceased's estate. 本人已經向法庭申請或已經被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 am entitle 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.
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權申請承辦死者的遺產的人士。

PART III : Detail of Records Request
第三部份：所需紀錄詳情

(a) Purpose of request 申請原因: _____

(b) Date of requested records 所需紀錄的期間: From 由_____To 至_____

(c) Requested Item 申請項目:

□	Hospital In-patient record 住院紀錄	□	Hospital Out-patient record 門診治療紀錄
□	Matilda Medical Centre / Matilda Clinic record 明德醫療中心/明德診所紀錄	□	Others (please specify) 其他(請注明): _____

PART IV : Payment Information
第四部份：收費資料

I do understand that there is a handling charge of HK$500 per patient record and this fee should be paid prior to the release of medical records as requested. 本人明白及預先繳付港幣 500 元正作為索取病歷紀錄副本之手續費用。

□ Cash **現金** □ EPS **易辦事**

□ Credit Card **信用咭** - Visa / MasterCard / Amex

Credit Card No. 信用咭號碼 :_____ Expiry Date **有效日期**: _____

Cardholder's Name **信用咭持有人姓名**: _____

□ Company Cheque **公司支票**
(Payable to **"Matilda International Hospital"** with applicant's name on the back)
(**支票抬頭為"明德國際醫院"及請於支票背後寫上申請人姓名**)

PART V: Collection Method (please choose ONE method only)
第五部份:領取方法 (請只選取其中一項)

□	Sent to my local address by courier service (additional charge will be required for addresses overseas): **速遞至本地地址 (海外地址需額外收費)** _____
□	Collected by myself (Please choose one location below for collection **請選擇以下其中一個地點領取**) □ Matilda International Hospital Main Reception **明德國際醫院接待處** □ Matilda Medical Centre (Central) **明德醫療中心 (中環)** The date of collection **領取日期**: _____
□	Collected by proxy **委派代理人領取** (Please present the identification upon collection **領取時請出示有效證明文件**) Proxy's name **代理人姓名**: _____ Proxy's HKID /Passport No. **代理人之香港身份證/ 旅遊証件號碼**: _____ Please choose one location below for collection **請選擇以下其中一個地點領取**: □ Matilda International Hospital Main Reception **明德國際醫院接待處** □ Matilda Medical Centre (Central) **明德醫療中心 (中環)** The date of collection **領取日期**: _____
□	Sent the PDF file to my email address **電郵 PDF 檔案至本人之電郵地址**

PART VI: Declaration
第六部份：聲明

I declare that the data provided by me is accurate and complete. I understand that if I fail to provide the information required or if the information provided is inaccurate or incomplete, my request may be rejected.
本人謹此聲明在申請表內提供的個人資料均屬準確及完整。我明白倘若我未能提供所需資料或提供不準確或不完整的資料，有可能導致我的申請被拒絕 。

_____	_____	_____
☐ Signature of the Applicant/ Patient (if 18 or above) 申請人 / 病人簽署 (如年滿 18 歲)	Full Name in Capitals 全名	Date 日期

☐ Signature of the Patient's parents / Legal Guardian
(If patient aged below 18)
病人父/母/合法監護人簽署 (如病人未年滿 18 歲)

☐ Signature of the Deceased's Next of Kin's
死者近親簽署

For any enquiry for requesting medical records, please contact Medical Records Office
如需查詢有關申請病歷紀錄事項, 請與本院之病歷紀錄部聯絡

Address 地址:	41 Mount Kellett Road, The Peak, H.K.	香港山頂加列山道 41 號
Office Hours: 辦公時間:	Mondays – Saturdays : 08:00-17:00 Sundays & Public Holidays: Closed	星期一至六: 08:00-17:00 星期日及公眾假期: 休息
Enquiry Telephone Number: 查詢電話:	2849 0481	
Fax Number: 傳真號碼:	2849 5175	
Enquiry Email: 查詢電郵:	medicalrecords@matilda.org	

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Information completed ☐	Signature ☐	Name of Staff issuing Notes:	
Patient Name ☐	Payment Received ☐ Invoice no. _____	Signature of Staff Issuing Notes:	
ID/ Passport ☐		Date of Issuing Notes:	
DOB ☐		Cross Checked by:	
Remarks:			