Adventist Health 港安 Hong Kong Adventist Hospital Stubbs Road

HEALTH RECORDS REQUEST FORM

(Please ✓ in the appropriate box)

1. Particulars of Patient

Name in English: ______________________ Name in Chinese: ______________________

Date of Birth: ______________ Sex: ☐ M ☐ F HKID/Passport No.: ______________________

Hospital No.: ______________________ Contact Tel. No.: ______________________

Address: ____

Update my personal particulars in the Hospital Information System: ☐ Yes ☐ No

2. Nature of Request

NOTE: To obtain copies of film / CD / DVD, please contact Diagnostic Imaging Dept. (2835-0515) directly.

****Date of requested document(s): From: ______________ To: ______________**

☐ Out-patient Consultation Note ☐ Laboratory Report

☐ In-patient Record ☐ Diagnostic Imaging Report

☐ Cardiac Assessment Report ☐ Immunization Record

☐ Full Medical Records (e.g.: All test reports, Out & In patient notes including nurses & doctors notes, etc.)

☐ Letter of Certification:

☐ Admission & Discharge Date ☐ Outpatient Date ☐ Birth Date & Time

☐ Medical Report (Dr & Content): ______________________

☐ Others (Please specify): ______________________

3. Collection Method

☐ Collect in person

☐ Send to the address mentioned above (Section 1)

☐ Collected by the third party: Name: ______________________

HKID / PP No.: ______________________

☐ Send to person / organization specified: Name: ______________________

Address: ______________________

____

4. Purpose of Request

☐ Further/future Medical Care ☐ Legal Proceedings ☐ Personal Record

☐ Other (please specify): ______________________

5. Payment Method

☐ Cash ☐ EPS ☐ Credit Card (Visa/Master/AE/Diners) ☐ Cheque

Patient No.: Name: Date of Birth: Gender: Room No.:	**HEALTH RECORDS REQUEST FORM**	
	Rev: Oct 2015	**MERD-MOJ01**

Item 6 is To be completed by the applicant if he / she is the parent / legal guardian of the patient aged below 18 or the deceased patient's personal representative / relative

6. Particulars of Applicant

Name in English: ____________________ Name in Chinese: ____________________

Sex: ☐ Male ☐ Female HKID/Passport No.: ____________________

Relationship with the Patient: ____________________ Contact Tel. No.: ____________________

To be completed if applying for deceased patient's data

Declaration: 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.

7. Declaration:

I declare that the data provided by me in this application is accurate and complete to the best of my knowledge. I hereby release the Hospital from any/all legal liability that may arise from the release of this information / records to me or to the party named above. I am aware that there will be fees for medical record copies and postage, and fees must be paid at the time of request.

______________________________ ______________________________

Signature of Patient / Legal Guardian / Deceased's Personal Representative

Date

Please return this form to: Medical Records Department, Hong Kong Adventist Hospital – Stubbs Road, 40 Stubbs Road, HK
Tel: (852) 3651 8809 Fax: (852) 2892 0950 Email: med.records@hkah.org.hk

For Staff Use Only	
Preparation Checklist: ☐ Full Name ☐ DOB ☐ Sex ☐ HKID/Passport No. ☐ Others: __________ Prepared by: __________ Date: __________ Checked by: __________ Date: __________	Releasing of Information Checklist: ☐ Full Name ☐ DOB ☐ Sex ☐ HKID/Passport No. ☐ Others: __________ Handled by: __________ Date: __________