The Chinese University of Hong Kong
University Health Service

Authorization Form for Release of Medical Information

[Photocopy of the completed form is as valid as the original]

1. Particulars of Patient

Name (surname first) ____

Patient No ________________________ (Staff Card / Student Card / HKID Card) *

Status: ☐ Student ☐ Staff ☐ Staff Dependent ☐ Retired Staff ☐ Retired Staff Dependent

☐ Others ________________________________ (please specify)

2. Medical Information Requested

Particulars	Details / Quantity	Period of Information
☐ Laboratory Report		
☐ Radiology Film/Report		
☐ Consultation Record		
☐ Medical Report		
☐ Others		

3. Authorized Person to whom the Medical Information is to be released *(if applicable)*

The patient and/or the patient's parent/guardian by signing this Authorization Form gives consent to University Health Service, The Chinese University of Hong Kong to disclose the medical information to the following person:

Name ________________________ HKID Card No ______________ Tel No _____________ Signature ___________
(in Block Letter)

4. Signature of Patient or Patient's Parent/Guardian

For patient who is over 18 years old	
Signature of Patient ______________________________	Date ______________________
For patient who is under 18 years old or unsound mind	
Signature of Patient's Parent/Guardian ________________	Date ______________________
Name (in Block Letter) ____________________________	HKID Card No _________________

* *Please delete as appropriate*
☐ *Please tick the appropriate box*

For UHS Use	
Application received on ________________________	Issued on ___________________________
☐ Checked Patient ID Proof (original by patient / copy by an authorized person)	Received HK$ ________________________
☐ Checked Patient's Parent/Guardian ID Proof (original)	Name of Staff ________________________
☐ Checked Authorized Person ID Proof (original)	Signature of Staff _____________________

(2022-07 version)

香 港 中 文 大 學
大 學 保 健 處

領 取 醫 療 紀 錄 授 權 書

[填妥授權書之副本與正本同樣有效]

1. 病人資料

姓名 (姓氏先行) ____

病人號碼 ____________________ (職員證 / 學生證 / 香港身份證) *

身份: ☐ 學生 ☐ 職員 ☐ 職員家屬 ☐ 退休職員 ☐ 退休職員家屬
☐ 其他 ______________________________ (請註明)

2. 所需醫療紀錄

項目	詳情 / 數量	資料日期
☐ 化驗報告		
☐ 醫療造影/報告		
☐ 診症紀錄		
☐ 醫療報告		
☐ 其他		

3. 獲授權領取醫療紀錄者 (如適用)

病人及/或其父/母/監護人簽署此表格代表病人及/或其父/母/監護人同意香港中文大學大學保健處向下述人士透露其醫療紀錄:

姓名(正楷) _______________ 香港身份證號碼 ______________ 電話號碼 _____________ 簽名 ___________

4. 病人或其父/母/監護人簽署

此欄適用於年滿十八歲之病人	
病人簽署 ______________________________________	日期 __________________________________
此欄適用於未滿十八歲之病人或因精神狀況而不能處理本身事務之病人	
病人父/母/監護人簽署 ____________________________	日期 __________________________________
姓名 (正楷) ______________________________________	香港身份證號碼 _______________________

* 請刪去不適用處
☐ 請在適當空格內加 ✓

大學保健處專用	
申請日期 __________________________	簽發日期 ______________________________
☐ 已核對病人身份証明 (由病人提供正本 / 由獲授權者提供副本)	已收款項 HK$ ____________________________
☐ 已核對病人父/母/監護人身份証明 (正本)	職員姓名 ______________________________
☐ 已核對獲授權領取醫療紀錄者身份証明 (正本)	職員簽署 ______________________________

(2022-07 修訂版本)