



香港中文大學 大學醫務處  
THE CHINESE UNIVERSITY OF HONG KONG  
UNIVERSITY MEDICAL SERVICE OFFICE

領取醫療紀錄授權書  
Authorization Form for Release of Medical Information  
[填妥授權書之副本與正本同樣有效]  
[Photocopy of the completed form is as valid as the original]

病人資料 Patient's Information			
姓名 (先填姓氏) Name (Surname first) _____		病人編號 (職員證/學生證/香港身份證)* Patient No (Staff Card/Student Card/HKID Card)* _____	
電話號碼 Tel No _____			
身份 Status: <input type="checkbox"/> 學生 Student <input type="checkbox"/> 職員 Staff <input type="checkbox"/> 職員家屬 Staff Dependent <input type="checkbox"/> 其他 Others _____ (請註明) (please specify)			
<input type="checkbox"/> 退休職員 Retired Staff <input type="checkbox"/> 退休職員家屬 Retired Staff Dependent			
所需醫療紀錄 Medical Information Requested			
項目 Particulars	詳情/數量 Details/Quantity		資料日期 Period of Information
<input type="checkbox"/> 化驗報告 Laboratory Report			
<input type="checkbox"/> 醫療造影/報告 Radiology Film/Report			
<input type="checkbox"/> 診症紀錄 Consultation Record			
<input type="checkbox"/> 醫療報告 Medical Report			
<input type="checkbox"/> 其他 Others			
病人或其父/母/監護人簽署 Signature of Patient or Patient's Parent/Guardian			
此欄適用於年滿十八歲之病人 For patient who is over 18 years old			
病人簽署 Signature of Patient		日期 Date	
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 For patient who is under 18 years old or unsound mind			
病人父/母/監護人姓名 (正楷) Name of Patient's Parent/Guardian (in Block Letter)		香港身份證號碼 HKID Card No	
病人父/母/監護人簽署 Signature of Patient's Parent/Guardian		日期 Date	
獲授權領取醫療紀錄者 (如適用) Authorized Person to whom the Medical Information is to be released (if applicable)			
病人及/或其父/母/監護人簽署此表格代表同意香港中文大學大學醫務處向下述人士透露病人醫療紀錄: The patient and/or the patient's parent/guardian by signing this Authorization Form gives consent to University Medical Service Office, The Chinese University of Hong Kong to disclose the medical information to the following person:			
獲授權者姓名 (正楷) Name of Authorized Person (in Block Letter)		香港身份證號碼 HKID Card No	
獲授權者簽署 Signature of Authorized Person		電話號碼 Tel No	

\* 請刪去不適用處 Please delete as appropriate  
☐ 請在適當空格內加 ✓ Please tick the appropriate box

大學醫務處專用 For UMSO Use	
申請日期 Application received on _____	簽發日期 Issued on _____
<input type="checkbox"/> 已核對病人身份證明 (由病人提供正本/由獲授權者提供副本) Checked Patient ID Proof (original by patient/copy by an authorized person)	已收款項 Received HK\$ _____
<input type="checkbox"/> 已核對病人父/母/監護人身份證明 (正本) Checked Patient's Parent/Guardian ID Proof (original)	職員姓名 Name of Staff _____
<input type="checkbox"/> 已核對獲授權領取醫療紀錄者身份證明 (正本) Checked Authorized Person ID Proof (original)	職員簽署 Signature of Staff _____