

## Application Procedure 申請程序：

1. Please complete this form accurately. The **administrative fee of HK\$300** should be paid before your request can be processed (See Part IV: Payment Information). Once approved, the administration fee is non-refundable. Please email this form, along with a **copy of your identification** and payment record or receipt, to the Medical Records Department.

請準確地填寫這份表格，在處理請求之前必須支付行政費用 HK\$300（請參考第四部分：收費資料）。一經批核，行政費用將不獲退還。請將此表格，連同身份證明文件副本及付款紀錄或收據，通過電子郵件發送至醫療記錄部。

Email 查詢電郵: **medicalrecords@matilda.org**

Office Hour 辦公時間: Mondays to Fridays: 08:00 to 17:00 星期一至五: 08:00 to 17:00

For hospital use only	
Reference No.:	
Hospital No.:	
Account No.:	
Request Date:	
Received by:	

2. If the fee exceeds HK\$300, the Medical Records Department will contact you to confirm the total charges for your request. 如費用超過港幣\$300，醫療紀錄部會聯絡您，告知您申請的總費用。
3. It takes 1 to 3 business days for us to confirm credit card payment or bank transfer. Applications with a total fee of no more than HK\$500 will be approved within **five working days** of payment confirmation. 我們需要 1-3 個工作天來確認信用卡付款或銀行轉賬，總收費不超過 HK\$500 的申請，將可在確認收款後五個工作天內完成審批程序。

## Part I: Particulars of the Patient 第一部份：病人資料

Surname as on I.D. Card 姓: \_\_\_\_\_ Given Name 名 / 別名: \_\_\_\_\_  
 Date of Birth 出生日期: \_\_\_\_\_ (Day 日) \_\_\_\_\_ (Month 月) \_\_\_\_\_ (Year 年) H.K.I.D. No. / Passport No. 身份證號碼 / 護照號碼: \_\_\_\_\_  
 Sex (on I.D. Card) 性別: \_\_\_\_\_ Tel No. (Mobile) 手提電話: \_\_\_\_\_ Email Address 電郵地址: \_\_\_\_\_

Please "✓" the appropriate box 請在適當方格上填上 "✓" 號

## Part II: Applicant Information 第二部份：申請人資料

**Myself 本人**

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

**Legal guardian of patients under 18 years old 18 歲以下病人的法定監護人**

Surname as on I.D. Card 姓: \_\_\_\_\_ Given Name 名 / 別名: \_\_\_\_\_  
 H.K.I.D. No. / Passport No. 身份證號碼 / 護照號碼: \_\_\_\_\_ Date of Birth 出生日期: \_\_\_\_\_ (Day 日) \_\_\_\_\_ (Month 月) \_\_\_\_\_ (Year 年)  
 Sex (on I.D. Card) 性別: \_\_\_\_\_ Relationship with Applicant 與申請人的關係: \_\_\_\_\_

- Please provide a copy of the patient's HKID / Passport / Birth Certificate or proof of legal guardianship. 請提供病人的香港身份證 / 護照 / 出生證明或法律監護權的證明。
- Please provide a copy of your HKID / Passport. 請提供香港身份證或護照副本。

**Personal representative of a deceased person 死者遺產代理人**

Surname as on I.D. Card 姓: \_\_\_\_\_ Given Name 名 / 別名: \_\_\_\_\_  
 H.K.I.D. No. / Passport No. 身份證號碼 / 護照號碼: \_\_\_\_\_ Date of Birth 出生日期: \_\_\_\_\_ (Day 日) \_\_\_\_\_ (Month 月) \_\_\_\_\_ (Year 年)  
 Sex (on I.D. Card) 性別: \_\_\_\_\_ Relationship with Applicant 與申請人的關係: \_\_\_\_\_

### Personal representative of a deceased person – Declaration 死者遺產代理人 – 聲明

I, the Applicant, declare the following: 本人聲明如下:

- I have applied for or been appointed by the Court as the personal representative or one of the personal representatives to administer the deceased's estate. 本人已經向法院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 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. 本人有權申請成為死者的遺產代理人或本人可作為代表所有權申請承辦死者的遺產的人士。
- Please produce the original or provide a certified true copy of the identity document of the deceased patient. 請提供已故病人的身份證明文件的原件或者經核證的真確副本。
  - Please provide a true copy of the documentary evidence of the relationship between the deceased patient and the applicant. 請提供已故病人和申請人之間關係的真實證據文件副本。
  - Please provide a copy of your HKID / Passport. 請提供香港身份證或護照副本

### Part III: Detail of Records Requested 第三部份：所需紀錄詳情

Purpose of request 申請原因: \_\_\_\_\_

Date of requested records 所需紀錄的期間: From 由 \_\_\_\_\_ (Day 日) \_\_\_\_\_ (Month 月) \_\_\_\_\_ (Year 年)  
To 至 \_\_\_\_\_ (Day 日) \_\_\_\_\_ (Month 月) \_\_\_\_\_ (Year 年)

Requested Item 申請項目:

- |  |   |
|--|---|
| <input type="checkbox"/> Hospital Inpatient record 住院紀錄  | <input type="checkbox"/> Hospital Outpatient record 門診治療紀錄      |
| <input type="checkbox"/> Matilda Medical Centre 明德醫療中心紀錄 | <input type="checkbox"/> Vaccination Record 疫苗接種記錄              |
| <input type="checkbox"/> Imaging requests 影像請求           | <input type="checkbox"/> Others (please specify) 其他(請注明): _____ |

Specific records requested 要求特定記錄: \_\_\_\_\_

- Request for paper copy 請求紙本副本 – additional charge HK\$5 per page 每頁需額外支付 HK\$5
- Save files to a USB 將檔案儲存到 USB - additional charge HK\$50 (includes local postage) 額外收費 HK\$50 (含本地郵資)

### Part IV: Payment Information 第四部份：收費資料

#### Medical Records - Softcopy 醫療紀錄-電子檔

**Document Format:** Prices are based on soft copy requests in PDF format

- **Administrative Fee:** HK\$300 (non-refundable, includes 10 pages of medical records)
- **Additional records:** HK\$200 for records covering 3 years (any year of your choice) or for requests exceeding 10 pages.
- **Records beyond 3 years:** An additional \$150 per year for records more than 3 years.
- **Vaccination Record:** \$500 (includes administrative fee).

**文件格式：**所有收費基於 PDF 文件格式

- **行政費用:** HK\$300 (不可退款，包含 10 頁醫療紀錄)。
- **額外記錄:** HK\$200 適用於涵蓋 3 年 (您選擇的任何年份) 的記錄或超過 10 頁的請求。
- **超過 3 年的紀錄:** HK\$150 (按年額外支付)。
- **疫苗接種記錄:** HK\$500 (含行政費)。

#### Imaging requests 影像請求

- \$300 (per procedure) (按每個程序收費) – Download Softcopy 下載電子檔
  - Please note that the Imaging files are provided with a built-in viewer software and are not in JPG format 請注意，影像檔案必須透過內建軟體查看，並非 JPG 格式
- Price to be confirmed for printed films 印刷影片的價格待確認

**Please select the payment method 請選擇付款方式**

- Online Payment** – send a screenshot or picture of the payment record  
在線支付 — 發送付款記錄的截圖或圖片

**PayMe**  
Scan or click the QR Code 掃描或點擊二維碼



**AlipayHK / WeChat Pay**  
Scan using the app 用應用程式掃描



- Credit Card** 信用卡 - Visa / MasterCard / Amex

Credit Card No. 信用卡號碼: \_\_\_\_\_ Expiry Date 有效日期: \_\_\_\_\_

Cardholder's Name

信用卡持有人姓名: \_\_\_\_\_

- Bank Transfer** (send a screenshot or picture of the payment record) 銀行轉賬 (發送付款記錄的截圖或圖片)

**Bank Name** 銀行名稱: The Hong Kong and Shanghai Banking Corporation Limited

**Account Name** 帳戶名稱: Matilda International Hospital

**Bank Code** 銀行代碼: 004    **Branch Code** 分行編號: 002

**Bank Account Number** 銀行賬戶號碼: 233856-001

**Part V: Collection Method (for USB or paper copy formats) 第五部份:領取方法 (適用於選定 USB 或紙本副本格式)**

- Send to the address below by courier service (additional charges apply for overseas addresses). 透過快遞服務送到如下地址 (海外地址將需額外收費)

Address 地址: \_\_\_\_\_

- Collection at (select location below) 在 (下面選擇的位置) 收集 :**

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)

**Scan for location information or visit our website**

掃描位置資訊或造訪我們的網

[www.matilda.org](http://www.matilda.org)



For collection by a proxy, please provide the details below and present an identity document upon collection 如由代理人收集，請提供以下詳情並於收集時出示身份證明文件：

Proxy's name

代理人姓名: \_\_\_\_\_

Proxy's HKID /Passport No.

代理人之香港身份證/ 旅遊證件號碼: \_\_\_\_\_

**Part VI: Declaration 第六部份：聲明**

I declare that the data I provided is accurate and complete to the best of my knowledge. I understand that if I fail to provide the required information or if the information I provide is inaccurate or incomplete, my request may be rejected. 本人聲明所提供的資料，是正確和完整。本人明白如果我未能提供所需的資料，或者提供的資料不正確或不完整，我的申請可能會被拒絕。

\_\_\_\_\_  
**Signature of Applicant 申請人簽名**

\_\_\_\_\_  
**Full Name in Block Letters 全名用大寫字母**

\_\_\_\_\_  
**Date 日期**

**For hospital use only**

Form completed with signature

Three patient identifiers checked

Supporting documents are available and correct

Payment received (Invoice No.: \_\_\_\_\_)

**Duplicate**

**Issued by:**

Signature &

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Remarks:**

**Checked by:**

Signature &

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Collected or sent**

**to the patient by:**

Signature &

Name: \_\_\_\_\_

Date: \_\_\_\_\_