# Notice for Application of Medical History
# 申請病歷資料須知

1. Please state clearly all the items in the application form.
請清楚填妥申請表內每一項資料。

2. Please complete the form in Chinese or English only.
申請表必須以中文或英文填寫。

3. A minimum of HK$10 per page per brief medical history and detail medical report per specialty subject to HK$300 or above. The fee will be confirmed upon requesting.
一般病歷資料每頁最低收費為港幣 10 元，而詳細醫學報告收費由港幣 300 元起至數千元不等視乎內容而定。當申請時將會確實應付之費用。

4. Please forward the Medical History Request Form together with the payment by cash or cheque directly to TY Medical Practice. All cheque must be strictly crossed and made payable to "TY Medical Practice Ltd".
請把病歷資料申請表格連同現金或支票付款直接交往天一醫務所。所有支票抬頭為『天一醫務所有限公司』。

5. No refund of the fee paid for a medical report will be made even if the application is withdrawal before the medical report is issued.
有關申請一經接納，所繳付之費用概不發還。

6. The processing time for brief medical history/detail medical report is about 1 to 2 weeks. The medical report will be ready to collect in TY Medical Practice while informed by our Clinic Service Associate.
一般病歷資料或詳細醫學報告需時一至二星期辦理，完成後本醫務所服務員將致電通知於天一醫務所領取。

# Medical History Request Form
# 病歷資料申請表格

**1. Particulars of Patient:**
**病人資料**

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

b) Gender: ☐ Male ☐ Female Date of Birth: _____ (yyyy)/____ (mm)/____ (dd)
性別 男 女 出生日期 年 月 日

c) HKID/Passport No : _____
香港身份証/護照號碼

d) Home Phone no : _____
住宅電話號碼

e) Mobile no : _____
手機號碼

**2. Information Requested from TY Medical Practice:**
**向天一醫務所索取的資料**

a) Period: from _____ to _____
期間： 由 至

b) Contents: (please tick the appropriate box)
內容 (請在適當空格上加上剔號)

☐ Brief Medical History
一般病歷資料

☐ Detailed Medical Report
詳細醫學報告

**3. Person to whom the medical history/report is to be sent (please tick the appropriate box)**
**病歷資料的接收人 (請在適當空格內加上剔號)**

a) ☐ The patient
病人本人

b) ☐ The patient's parent/guardian
病人父母/監護人

The patient and/or the patient's parent/guardian by signing this form consents to TY Medical Practice disclosing and giving the medical report to the following person:
病人及/或其父母/監護人簽署此表格同意天一醫務所向下述人士透露及發出其病歷資料

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

HKID/Passport No : _____
香港身份証/護照號碼

Home Phone no : _____
住宅電話號碼

Mobile no : _____
手機號碼

Home Address : _____
地址

Relationship with the patient: _____
與病人關係

(if patient is a minor or mentally incapable)
(此欄適用於未滿十八歲或因精神狀況而不能處理本身事務之病人)

_____
Signature of the Patient
病人簽署

_____
Date
日期

_____
Signature of the patient's parent/guardian
病人父母/監護人簽署

_____
(Name in Block Letters)
姓名(請用正楷填寫)

_____
HKID/Passport No
香港身份証/護照號碼

_____
Date
日期