



Tuberculosis & Chest Service

Application Form for Medical Report/ Copy of Medical Record/ X-ray film*/ disc®

Application Notes

1. Application documents

Applicant should complete the application form and submit together with the following documents:

- a. A copy of patient's identity document.
- b. For patient aged under 18, please also submit (i) a copy of the patient's birth certificate, (ii) a copy of the identity document of the applicant (parent/ guardian), and (iii) a copy of documentary proof of guardianship if applicable.
- c. For the requests from patient representatives/ third parties (e.g. insurance companies, law firms, etc), please also submit (i) the documentary evidence that patient's consent has been obtained, and (ii) a copy of the applicant's identity document if the application is not submitted by a company.
- d. For the application of medical information of a deceased patient, please also submit (i) a copy of patient's death certificate, (ii) a copy of the applicant's identity document, and (iii) a copy of documentary evidence showing the relationship between the applicant and the deceased (e.g. marriage certificate, birth certificate, etc).

In the process of application, supplementary information/document might be required. Insufficient or incorrect information may cause delay or failure in processing the application.

2. Charges

- a. Payment of a standard charge of HK\$800 per medical report requested. For supplying a copy of the X-ray film/ disc under request, processing fee and duplication charges are payable. The processing fee is HK\$76 per request. The duplication charge is HK\$230 per film/ disc. For the application for copy of medical record, a charge reflecting the cost of photocopying will be imposed. Upon initial processing, the applicant will be informed of the amount of photocopying or duplicating charges payable. Payment must be made at the time of request.
- b. A crossed cheque shall be made payable to "The Government of the Hong Kong Special Administrative Region". Please write down your name, identity document number and contact number on the back of the cheque. If you wish to pay in cash, please visit the respective chest clinics/ X-ray centres in the registration hours (Please refer to the link [here](#) and also to Table 1 for the addresses) in person. Cash should NOT be sent by post. Charges are non-refundable once the application is confirmed.

3. Submission of Application

In person or by post to respective chest clinics/ X-ray centres (please refer to Table 1 for the addresses)

4. Processing Time

The application will be processed after confirmation with you on the application and relevant charges. Processing time is normally about 3 to 4 weeks. The medical report and/ or copy of medical record, together with an official receipt, will be sent to the collection point or address that is specified in the application. For X-ray film and/ or disc, please collect in person at respective chest clinics/ X-ray centres (Please refer to the link [here](#)). You will be notified when the document is ready for collection. If the document is not collected within 3 months after notification, the document will be destroyed without further notice and no refund of charges paid will be made.

5. Format

All medical reports/ medical records are written in English. Department of Health reserves the right to provide the medical report/ medical record/ X-ray film/ disc in our prescribed format.

6. Statement of Purpose

All copies of Identification Documents will be used solely for the purpose of this request. The personal data provided will be used for processing the application and record management. For details, please refer to the Statement of Purposes for Collection of Personal Data.

7. Enquiry

For any enquiries, please contact the respective chest clinics/ X-ray centres with details linked [here](#).

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Chest Clinics	Address
<i>Full-time chest clinics</i>	
<i>Hong Kong Island</i>	
Sai Ying Pun Chest Clinic (SYGCC)	2/F, Sai Ying Pun Jockey Club Polyclinic, 134 Queen's Road West, Hong Kong
Shaukeiwan Chest Clinic (SKWCC)	2/F, Shaukeiwan Jockey Club Polyclinic, 8 Chai Wan Road, Shau Kei Wan, Hong Kong
Wanchai Chest Clinic (WCC)	1/F, Wanchai Polyclinic, 99 Kennedy Road, Wanchai, Hong Kong
<i>Kowloon</i>	
East Kowloon Chest Clinic (EKCC)	G/F, East Kowloon Polyclinic, 160 Hammer Hill Road, Kowloon
Kowloon Chest Clinic (KCC)	G/F, 147A, Argyle Street, Kowloon
Shek Kip Mei Chest Clinic (SKMCC) [^]	1/F, Shek Kip Mei Health Centre, 2 Berwick Street, Kowloon [Postal address: 2/F, Wanchai Polyclinic, 99 Kennedy Road, Wanchai, Hong Kong]
Yaumatei Chest Clinic (YMTCC)	2/F, Yaumatei Jockey Club Polyclinic, 145 Battery Street, Kowloon
Yung Fung Shee Chest Clinic (YFSCC)*	1/F, Yung Fung Shee Memorial Centre, 79 Cha Kwo Ling Road, Kowloon
<i>New Territories & Islands</i>	
South Kwai Chung Chest Clinic (SKCCC)	G/F, 310 Kwai Shing Circuit, Kwai Chung, New Territories
Tai Po Chest Clinic (TPCC)	1/F, Tai Po Jockey Club Clinic, 37 Ting Kok Road, Tai Po, New Territories
Yan Oi Chest Clinic (YOCC)	2/F, Yan Oi Polyclinic, 6 Tuen Lee Street, Tuen Mun, New Territories
Yuen Chau Kok Chest Clinic (YCKCC)	1/F, 29 Chap Wai Kon Street, Sha Tin, New Territories
<i>Part-time chest clinics[^]</i>	
Cheung Chau Chest Clinic (CCCC)*	G/F, St John Hospital, Cheung Chau Hospital Road, Tung Wan, Cheung Chau [Postal address: 1/F, Wanchai Polyclinic, 99 Kennedy Road, Wanchai, Hong Kong]
Sai Kung Chest Clinic (SKCC)	G/F, Mona Fong Clinic, 23 Man Nin Street, Sai Kung, New Territories [Postal address: 1/F, 29 Chap Wai Kon Street, Sha Tin, New Territories]
Sheung Shui Chest Clinic (SSCC)	1/F, Shek Wu Hui Jockey Club Clinic, 108 Jockey Club Road, Shek Wu Hui, Sheung Shui, New Territories [Postal address: 1/F, 29 Chap Wai Kon Street, Sha Tin, New Territories]
Tung Chung Chest Clinic (TCCC)	1/F, Tung Chung Health Centre, 6 Fu Tung Street, Tung Chung, Lantau Island [Postal address: 1/F, Tung Chung Health Centre, 6 Fu Tung Street, Tung Chung]
Yuen Long Chest Clinic (YLCC)	G/F, Yuen Long Jockey Club Health Centre, 269 Castle Peak Road, Yuen Long, New Territories [Postal address: 1/F, 29 Chap Wai Kon Street, Sha Tin, New Territories]
<i>X-ray Centres</i>	
Sai Ying Pun X-ray Survey Centre	7/F, Sai Ying Pun Jockey Club Polyclinic, 134 Queen's Road West, Hong Kong
Radio-diagnostic & Imaging Centre (Kowloon Bay)	10/F, Kowloon Bay Health Centre, 9 Kai Yan Street, Kowloon Bay
Radio-diagnostic & Imaging Centre (Fanling)	5/F, Fanling Health Centre, 2 Pik Fung Road, Fanling
<i>Pneumoconiosis Clinic</i>	
Pneumoconiosis Clinic (PC)	4/F, Shaukeiwan Jockey Club Polyclinic, 8 Chai Wan Road, Shau Kei Wan, Hong Kong

[^] For applications to SKMCC and part-time chest clinics, please send to the postal address as listed.

* For the request of copy of X-ray film or disc from YFSCC and CCCC, please contact the respective chest clinic for the details of application.

® X-ray disc is only applicable if X-ray is kept in electronic format.

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- To:
- | | | |
|---|--|--|
| <input type="checkbox"/> SYPCC | <input type="checkbox"/> SKWCC | <input type="checkbox"/> WCC |
| <input type="checkbox"/> EKCC | <input type="checkbox"/> KCC | <input type="checkbox"/> SKMCC |
| <input type="checkbox"/> YMTCC | <input type="checkbox"/> YFSCC* | <input type="checkbox"/> SKCCC |
| <input type="checkbox"/> TPCC | <input type="checkbox"/> YOCC | <input type="checkbox"/> YCKCC |
| <input type="checkbox"/> CCCC* | <input type="checkbox"/> SKCC | <input type="checkbox"/> SSCC |
| <input type="checkbox"/> TCCC | <input type="checkbox"/> YLCC | <input type="checkbox"/> PC |
| <input type="checkbox"/> Sai Ying Pun
X-ray Survey
Centre | <input type="checkbox"/> Radio-diagnostic &
Imaging Centre
(Kowloon Bay) | <input type="checkbox"/> Radio-diagnostic &
Imaging Centre
(Fanling) |

(Note: Please only submit application to ONE clinic/ centre in each application form.)

Section 1: Particulars of Applicant

Please indicate if the applicant is the patient:

- Yes (please complete Section 1) No (please complete Sections 1 and 2)

Name: _____

(English in block letters)

(Chinese)

Sex: Male Female

Hong Kong Identity Card No.: _____ OR Passport No.: _____

Contact Address: _____

Contact No.: _____

Section 2: Particulars of Patient (to be completed if the applicant is not the patient)

(Note: Please refer to paragraph 1 of "Application Notes" for the documents required for the application.)

Name: _____

(English in block letters)

(Chinese)

Sex: Male Female Relationship with the applicant: _____

Hong Kong Identity Card No.: _____ OR Passport No.: _____

Contact Address: _____

Contact No.: _____

Please tick (✓) as appropriate

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Department of Health

Section 3: Details of Medical Report/ Copy of Medical Record/ X-ray film/ disc under Request			
<input type="checkbox"/>	Medical Report		
<input type="checkbox"/>	Medical Consultation Note	Period: from _____ to _____	
<input type="checkbox"/>	Laboratory Result (<i>please specify the type of test</i>): _____	Period: from _____ to _____	
<input type="checkbox"/>	X-ray film*	Period: from _____ to _____	
<input type="checkbox"/>	X-ray disc [®]	Period: from _____ to _____	
<input type="checkbox"/>	Others (<i>please specify</i>): _____	Period: from _____ to _____	

Section 4: Purpose of Application	
<input type="checkbox"/> For medical follow-up <i>(Note: please provide relevant document such as official note by medical practitioner if any.)</i>	<input type="checkbox"/> For insurance claim
<input type="checkbox"/> For personal record	<input type="checkbox"/> Others (<i>please specify</i>): _____

Section 5: Method of Collection
<input type="checkbox"/> In person at respective chest clinics/ X-ray Centres
<input type="checkbox"/> By registered post **
<input type="checkbox"/> Applicant's contact address (same address as Section 1 indicated)
<input type="checkbox"/> The following person/ organisation:
Recipient Name: _____
Recipient Address : _____
Recipient Contact No.: _____

** Not applicable to collection of X-ray film/ disc

Section 6: Declaration and Consent
<input type="checkbox"/> I have read and agreed the aforementioned "Application Notes".
<input type="checkbox"/> I declare that the information given in this application is accurate. I by signing this Form authorise/ have obtained patient's authorization [#] to Tuberculosis and Chest Service of the Department of Health to disclose the medical report, copy of medical record, X-ray film or disc under this application to me/ the recipient [#] in Section 5 above.
Signature of Applicant/ Patient: _____
Name of Applicant/ Patient: _____
Date: _____

[#] Please delete as appropriate.

Please tick (✓) as appropriate.

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