Name of Requesting Doctor (in Block Letter) _____	To: _____ Hospital
Fax No: _____	Contact Person: _____
Telephone No: _____	Fax No: _____
Date: _____	_____
See Note 6	

DISCHARGE SUMMARY / CONSULTATION SUMMARY PATIENT'S CONSENT FORM

Patient's Name (English) _____ Chinese _____

Sex _____ Age _____ HKID Card No. _____

This consent form is only valid within 3 months starting from the date signed by the Patient or Patient's Parent/Guardian/Next-of-kin (as the case may be).

A. CONSENT

I, the undersigned, consent to the Hospital Authority, its hospitals and subsidiaries providing my/the patient's medical summary/summaries to my/the patient's doctor, related to the episode(s): (please ☜ the appropriate)

☐ when I/the patient was discharged on _____ .

☐ when I/the patient has attended the Out-patient Clinic (please specify the specialties: _____)

B. PERSON(S) SIGNING THIS FORM

The person(s) signing this form is/are: (please tick as appropriate)

☐ The patient

☐ The patient's parent/guardian/next-of-kin: (please specify)

Name in Block Letters _____

HKID Card / Identity Document No. _____

Address _____

Phone No. (Day) _____ (Night) _____

Relationship with the Patient _____

Signature of Patient See Notes 1,2 & 3	Date
Signature of Patient's Parent/Guardian/Next-of-kin See Notes 1,2 & 3	Signature of Witness See Note 5
Signature of the Doctor providing the Explanation See Note 4	Name of the Witness in Block Letters
Name of the Doctor in Block Letters	HKID Card or Identity Document No. of the Witness

Note 1: This form is to be signed by an adult patient. Should the patient be unfit or unable to do so, the next-of-kin should sign this Form to indicate support or patient's consent.

Note 2: For a minor who is under 18 years of age and can understand the contents of this Form and the explanation given, only the minor need sign this Form. Whenever appropriate, both the minor and the parent/guardian should sign this Form.

Note 3: When an adult/a minor cannot understand the contents of this Form and the explanation given because of mental incapacity/age, only the patient's guardian/parent need sign this Form.

Note 4: This Form should be signed by the doctor who gave the explanation to the patient and/or patient's parent/guardian/next-of-kin.

Note 5: The witness should be involved in the whole process - from the explanation giving to the signing of the Form. Please leave the witness fields blank in the absence of witness.

Note 6: Name and Fax Number of the Requesting Doctor must be identical with the information in the ALMCHK doctors' directory otherwise the request will be rejected by the Hospital Authority.