

Kaohsiung Veteran General Hospital Request for Medical Record Copy and Authorization Letter

Version 20200130

Application Date: (MM) (DD), (YYYY) Medical Record No.

Patient Name		Date of Birth	(MM) (DD), (YYYY)	ID No. (ARC No.)	
Contract Tel		Discount Qualification	<input type="checkbox"/> Veteran <input type="checkbox"/> Police and military <input type="checkbox"/> Low income <input type="checkbox"/> Out-patient clinic, emergency, admission	Signature of Attending Physician (out-patient clinic and admission only)	

Purpose	<input type="checkbox"/> Insurance <input type="checkbox"/> Referral <input type="checkbox"/> Military service <input type="checkbox"/> Overseas travel <input type="checkbox"/> Lawsuit <input type="checkbox"/> Subsidy application <input type="checkbox"/> Administrative autopsy <input type="checkbox"/> Other:
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	Item	Time Range and Department	# of copy	
Application Item and Range	<input type="checkbox"/> Out-patient medical record			
	<input type="checkbox"/> Discharge letter summary (<input type="checkbox"/> Emergency <input type="checkbox"/> Admission)			
	<input type="checkbox"/> Diagnosis certificate (copies are available only if issued by the doctor)			
	<input type="checkbox"/> Inspection/Examination report			
	<input type="checkbox"/> Medical record summary in Chinese version			
	<input type="checkbox"/> Image inspection <input type="checkbox"/> CD-ROM	<input type="checkbox"/> X-ray report <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Ophthalmology	<input type="checkbox"/> MRI report <input type="checkbox"/> PET report <input type="checkbox"/> Angiocardiology	<input type="checkbox"/> CT report <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Other: _____			

Fee Rates	<p>◎ The hospital charges the fees according to the standard rate schedule published by the Department of Health, Kaohsiung City Government. Please read the following information:</p> <ol style="list-style-type: none"> Medical records copy in paper version: NT\$200 (discounts are available to veterans, policy and military officials, low income patient, and for outpatient/emergency/admission case. Proof and certificate required), medical records: NT\$ 5 per page, NT\$ 100 per page for color photocopies, diagnosis certificate: NT\$ 50 per copy. Image inspection CD-ROMs are burnt by department (NT\$ 200 per inspection serial number per department. Maximum NT\$ 500 per CD-ROM. Data size exceeding the storage of one CD-ROM: additional NT\$ 100 per CD-ROM) Medical record summary in Chinese version: NT\$ 1,000 per copy. Applicant will be contacted by phone when documents are available for pick-up. <p>◎ Request for medical record and image inspection CD-ROM can be processed at the payment counters of Community Health Center on the first floor of the Outpatient Department Building, Admission Service Center on the first floor of the Medical Building, and on the first floor of the Senior Care Building (only open to admitted patients in the Senior Care Building).</p> <p>◎ Request for medical record of admitted patient will be processed by the nurse station of the ward, subject to the signature of the attending physician. Fees will be credited to the hospitalization bill. Please make the payment and pick up the documents at the payment counter at the Admitted Patient Service Center or the Senior Care Building.</p> <p><input type="checkbox"/> I agree that I will be charged according to the information above and I have confirmed the item in my request.</p>
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Pick-up Method	<input type="checkbox"/> By applicant <input type="checkbox"/> By authorized individual (please fill out the authorization letter on the reverse page)
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<input type="checkbox"/> By post [Available only for full packet of medical information. A fee of NT\$ 2,280 will be charged upon request. (Postage included, remaining balance will be refunded by post draft. Image inspection CD-ROM will incur an additional NT\$ 500 fee.)]				
Authorized Person		Contact Tel.		ID No. (ARC No.)
ID Document	Patient	<input type="checkbox"/> Original ID of patient (the photo should be clear and identifiable) <input type="checkbox"/> Other _____		
	Authorized Person (Relationship with the patient:)	<input type="checkbox"/> Original ID of patient (the photo should be clear and identifiable) <input type="checkbox"/> Authorization letter (wet signature)		
Request received by	Image reproduced by	Fee calculated by (payment at the Community Health Center or Admitted Patient Service Center)	Pick-up service by	Receipt by application (authorized person)
	(CD-ROM fee: NT\$)			(specify date)

※Please fill out the satisfaction survey on the reverse page to support us!

Required documents for medical records request and pick-up:

- A- Application by patient: Original ID document
 B- Application by others:
1. Request by authorization: a. original ID of the patient, b. original ID of the authorized person, c. complete authorization letter issued by patient
 2. Request for a minor must be submitted by the legal representative: a. original ID of the legal representative, b. proof of relationship between the legal representative and the patient (household registration, original ID of the patient)
 3. Request for a deceased: a. original ID of the heir or direct lineal relative, b. document of relationship with the patient or documented proof of inheritance right, c. proof of removing the patient from the household registration (household registration transcript or death certificate)
 4. Request for a minor/ deceased by a third party authorized by the legal representative/ heir or direct lineal relative: a. ID document described in points 2 and 3, b. authorization letter issued by the legal representative or the heir or direct lineal relative, specifying the reason and scope, c. original ID of the authorized person

【Authorized letter is required for any request submitted by anyone other than the patient or the legal representative of a minor】

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Standard request

Authorization Letter

The undersigned, _____, is unable to submit the request personally, and hereby authorize my representative to submit the request. The requested items are as specified in the "Request for Medical Record and Authorization Letter". If the authorized representative requests for any information beyond the scope or uses the information for any other purpose, the authorized representative will be held liable and the hospital does not undertake any responsibility. The undersigned or the patient/his or her legal representative hereby waive any claim against the hospital.

TO Kaohsiung Veteran General Hospital

Signed by _____ (signature)

Name of authorized person _____ (signature and stamp)

Date: (MM) (DD), (YYYY)

Administrative autopsy (Leave blank for standard request)

Authorization Letter

The patient _____ **has deceased** on (MM) (DD), (YYYY). The request is submitted by _____ (relationship:). Any misstatement will be subject to legal penalty.

Name of heir or direct lineal relative _____ (signature and stamp)

Date: (MM) (DD), (YYYY)

⊙ Satisfaction Survey

Please help us improve the process quality of our medical record request by filling out the survey below. We appreciate your opinion as our reference for improvement.

Item Instruction: Mark "V" under the applicable level of satisfaction	Very Satisfied	Satisfied	Average	unsatisfied	Very unsatisfied
1.Pick-up waiting time					
2.Service attitude					
3.Medical record copy clarity					
4.Overall satisfaction					
5.Other feedback:					

Thank you for your precious feedback. We wish you happy, health and safe!!