Kaohsiung Armed Forces General Hospital Medical Record Application Form and Power of Attorney

<table>
<tr><td>Name</td><td></td><td>Date Of Birth</td><td></td><td>Passport Number</td><td></td></tr>
<tr><td>Contact Telephone Number</td><td colspan="2">Home Phone：
Cellphone Number：</td><td>Information Purposes</td><td colspan="2">☐Referral ☐Go Abroad
☐Reference ☐Insurance ☐litigation
☐Military Service ☐Other_____</td></tr>
<tr><td colspan="2">Type of application
(Please Need the Item∨)</td><td>During the Period</td><td>Number of Copies</td><td colspan="2">Application Unit</td></tr>
<tr><td>☐Summary of Hospitalized Medical Records
☐Nursing Record
☐Hospitalized Medical Records All</td><td>☐Surgical Record
☐Ambulance Record Form
☐Other_____</td><td></td><td></td><td colspan="2">☐Outpatient、Emergency
☐Inpatient department
☐Website
☐Medical Service Counter
☐Other_____</td></tr>
<tr><td colspan="2">☐Outpatient Medical Records ☐Part
☐Emergency medical records
☐All (Summary of Hospitalized Medical Records)</td><td colspan="2">☐已通知取件</td><td colspan="2">☐補證件</td></tr>
<tr><td colspan="2">☐Inspection Report ☐All
☐Part ☐Other_____
☐Inspection Report ☐All
☐X-ray ☐Pathology ☐Ultrasound ☐EKG ☐CT
☐MRI ☐Other_____</td><td colspan="2" rowspan="2">☐需補收費用
元</td><td colspan="2">主治醫師簽章</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Number of Photocopies</td><td colspan="2">共_____張_____元</td><td>收費蓋章</td><td colspan="2">基本費 100 元</td></tr>
<tr><td>Remarks</td><td colspan="5">※To protect the rights and interests of patients, apply for information please prepare the relevant documents：
1. Applicant：ID card or Passport.
2. Agent：⑴Patient ID card or Passport.⑵Agent ID card or Passport.⑶Patient's Power of Attorney
※Reception time：Mon-Fri(08:00-16:30)；Sat(08:00-11:30)。</td></tr>
</table>

☐Mailing (Please enclose the envelope and enclose the name and address of the recipient)申請日期:___年___月___日

Signature:

完成日期:___年___月___日

Power of Attorney

I really can not personally apply for medical records，commissioned _____ (with my relationship：_____)，On behalf of the hospital to apply for the above medical records, this trust behavior as their own behavior, and I bear all the responsibility.

Name of trustee：_____ (Signature) Contact phone number：