



高雄榮民總醫院 國際醫療中心

Kaohsiung Veterans General Hospital (KSVGH)

Department of International Medical Service Center, IMSC

TEL:+886-7-342-2121#75914

國際醫療病人身分確認單 IMSC Applicant Consent

<u>Registration Form</u>														
ROC National Health Insurance						Visit Date: _____ yy/ _____ mm/ _____ dd								
Yes		No	✓	Medical Record No. _____										
Family Name			First Name			M		Birth Date		Year	Mon	Day	Nationality	
(中文填寫)			F											
Passport No. or Residency Card No.												Marital Status	M 已婚	
												S 未婚		
Local Address		(中文填寫)						Phone		(O)				
										(H)				
E-mail														
Emergency Contact		Name: _____ (中文填寫)						Phone: _____						
		Address: _____ (中文填寫)												
Department:				Clinic:				Doctor:						

國際醫療病人 Applicant :

- 新個案，請完成以上表格，並請附上病人**護照影本**，以電子郵件或傳真回傳至本中心，以利辦理預約掛號手續。聯絡資訊如下：

New applicant must fill in the registration form attached with **passport copy** and send back to IMSC via Email or Fax. Contact information as follow:

電子郵件 Email:imc@vghks.gov.tw

以上經病人同意後，於本院產生所有費用將依國際醫療身分計價，除外籍人士取得健保身分證明始得更改身份為健保，無法恣意變更就診身份。

Applicant must agree the identity of IMSC patient which cannot be revised in any circumstance. Medical services provided by KSVGH will be charged according to IMSC standard.

簽名 Signature : _____

年 yy 月 mm 日 dd



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1. Personal information collection, processing and use

(1) I agree that your hospital may collect, process or use my medical records and related information for medical treatment, care services or other specific purpose as follows:

(2) I agree disagree

Under the premise of health and care services, your hospital may process and use my medical records and related information collected from your hospital. If consent is not given, the hospital will be unable to process and use medical records and related information.

2. Use for non-specific purposes

According to articles 5 to 9, 16 and 20 of the Personal Information Protection Act,

I agree disagree

The hospital may contact you regarding physician service hour changes or on behalf of the clinic, information regarding health education, health checks, patients' club, hospital news, outpatient schedule, new medical knowledge, teaching activities, care and satisfaction related information through letter, e-mail, SMS, fax or telephone. If consent is not given, the hospital will be unable to contact you for the above-mentioned information.

3. I have read this document carefully and fully understand the contents and agree to abide by the stated conditions. Any objections to this agreement subsequent to consent being given shall result in the termination of rights for use.

Signature of Consent:

Relationship:

Address:

Tel:

Date: (Year)

(Month)

(Day)

Note:

1. For specific purposes as promulgated by the Ministry of Justice, refer to the notes on the back, please.
2. For specific categories as promulgated by the Ministry of Justice, refer to the notes on the back, please.
3. Deliver this completed form along with ID card or driver's license or NHI card to the counter clerk for handling.

Filed by:

MR2-011e