Taichung Armed Forces General Hospital Basic Information and Personal Data Consent Form Taichung

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□ Initial visit □ Follow up □ Physical examination

※New patients are required to provide their ID card and health insurance card

Section 1: Basic Personal Information

Name			ID No./Passport No.				
			Date of Birth			(YYYY) (MM) (DD)	
Blood Type	□ A □ B □ O □ AB	Gender	□ M □ F	Marital Status	□ Married □ Single	Phone/Cell Phone	
Address on Household Registration	□ County □ City □ Township □ Town □ District □ Community □ Village Road Lane No.						
Mailing Address	□ Same as above;						
Height	cm	Weight	Kg	Occupation	None, military, government, industry, commerce, agriculture, freelance, housewife/house husband, other_____		
Drug Allergy	□ Yes：_____ Drug □ None			Smoking	□ Yes：About ____ cigarettes per day/have smoked for about ____ years □ None □ Quitted (About ____ years)		
Emergency Contact Name		Phone/Cell Phone			Relationship		
Full Title at Work (To be completed by soldier)			Branch of service		Military rank		

Section 2: Personal Data Protection Management Consent Form

The Personal Data Protection Act was implemented on October 1, 2012 as amended. In order to protect your rights, this hospital intends to provide the following explanations regarding the data (including information prior to signing) retained during your medical visits:

1. Collection, Processing and Use of Personal Data

I agree that this hospital (including the Zhongqing Branch) may collect, process, or use my medical records and related information for medical, healthcare services-providing, medical administrative, or specific purposes (as noted and explained on the reverse side).

2. Requesting a copy of medical records from the original hospital or clinic

Article 74 of Medical Care Act: "A hospital or clinic, when treating a patient, may, as necessary and with the consent of the patient or patient's legal representative, spouse, family member, or a related person, negotiate with the original hospital or clinic that treated the patient to provide copies of medical records, medical summaries, and examination/test reports."

□ Agree □ Disagree (If disagree is checked, the hospital will not be able to perform cross-hospital medical record inquiries)

3. Use beyond Specific Purposes

I have used and will use the following items during my visit to this hospital (including the Zhongqing Branch).

The hospital collects, processes, and utilizes related data in accordance with Articles 5, 8, and 9 of the Personal Data Protection Act, and distributes the following information through contact methods such as mail, email, text messaging, fax, and phone: Health education, health check-ups, patient support groups, hospital newsletters, outpatient schedules, medical news, educational activities, care and satisfaction surveys, abnormal test results notifications, cancer screenings, free clinics, community activities, health promotion, and music and cultural events.

□ Agree □ Disagree (If disagree is checked, the hospital will not be able to provide the information above)

I have carefully read this document, and after asking questions and receiving answers, I fully understand the content and agree to comply with it. This consent form can be revoked if you have objections in the future by requesting to stop the use of your data.

Notes: 1. For the specific purposes and categories of personal data as announced by the Ministry of Justice, please refer to the table below.
2. If the consenter is a minor or has a mental disability, the form may be signed by a direct relative or legal representative.
3. Please submit the completed form along with your ID card or driver's license and health insurance card to the front desk staff for processing.
4. If there are any changes to the information in the future, please inform the nurse or receptionist during your visit or registration to facilitate corrections.

Please turn the page

Section 3: Consent Form for Providing Medical Records and Result Information

Section 3: Consent Form for Providing Medical Records and Result Information

I, _____, agree that the physicians, for the purpose of diagnosing my medical condition, and pharmacists, for the purpose of providing medication consultations or guidance to me, of the **Taichung Armed Forces General Hospital (and Zhongqing Branch)** may access my medical records for up to **7** years from the date I sign this consent form, through the National Health Insurance (NHI) medical information cloud query system (including the NHI cloud-based prescription history system) established by the National Health Insurance Administration of the Ministry of Health and Welfare (hereinafter referred to as the NHI Administration), in accordance with the relevant regulations of the National Health Insurance Act, to carry out the following operations:

I. Downloading my medical expense claims and the medical data uploaded via my health insurance card from the query system. (Including information such as medication records, examinations and tests, surgical procedures and dental treatments)
II. Online inquiry and downloading of my medical result data from the inquiry system uploaded by each contracted medical service institution. (Including data such as examination (test) reports, examination (test) image files, and discharge summary)

The aforementioned information is only for use when a physician at Taichung Armed Forces General Hospital (and Zhongqing Branch) needs to query and compare the data for diagnosing my condition and for a pharmacist there to provide medication consultation or guidance to me. The information cannot be used for any other purpose. After I complete the visit, the downloaded information should be deleted. However, this does not include the information that has been downloaded and included in my medical records by the physician for medical purposes.

In accordance with Article 3 of the Personal Data Protection Act, I reserve the right to withdraw this consent form or modify the contents of this consent form at any time.

Sincerely **Taichung** Armed Forces General Hospital (and Zhongqing Branch)

Consenter Signature: _____

ID No.: _____

Date of Birth: _____MM_____DD_____YYYY

Representative: _____

ID No.: _____

Relationship to patient: _____

MM DD YYYY

Signing assisted by		Record created by	

"Specific Purposes and Categories of Personal Data under the Personal Data Protection Act"

Specific Purposes:

Code	Items for specific purposes
064	Healthcare services