

Declaration by _____ (Name of Healthcare Provider)

Acting as Substitute Decision Maker (SDM) of Healthcare Recipient (HCR)

To whom it may concern,

We hereby certify that the following HCR is currently receiving healthcare services at

_____ (Name of Healthcare Provider).

	Name	Identity card number (English letter and first 4 digits)
Example:	CHAN Tai Man	E5678
1		
2		
3		
4		
5		

The above HCR is under the age of 16; or the HCR is aged 16 or above and incapable of giving a consent on his/her own, and does not have any of the following eligible SDM:

- a person appointed under or acting by virtue of the Guardianship of Minors Ordinance (Cap. 13) or appointed by the court¹;
- the parent of the HCR¹;
- a person appointed as guardian of the HCR under the Mental Health Ordinance (Cap. 136) (MHO)²;
- the Director of Social Welfare or that other person who, pursuant to section 44A(1)(i) of the MHO, as guardian²;
- the Director of Social Welfare who, pursuant to section 44B(2A) or 59T(1) of the MHO, is vested the guardianship of the HCR, the Director of Social Welfare²;
- the Director of Social Welfare or that other person who, pursuant to section 44B(2B) or 59T(2) of the MHO to perform the functions of a guardian for the HCR, the Director of Social Welfare or that other person²;
- a person appointed by the court to manage the affairs of the HCR; and
- a family member of the HCR or a person residing with the HCR.

Notes

1. Applicable only to HCR under the age of 16.
2. Applicable only to HCR aged 16 or above.

Accordingly, as a prescribed healthcare provider currently providing healthcare to the above HCR, this institution will assist, in the capacity of SDM, with the registration and related matters of the Electronic Health System (eHealth).

In addition, this institution has appointed (Name of Staff: _____ and Staff ID No.: _____) to handle all related administrative matters on behalf of this institution for the above HCR. A copy of the staff member's identification card is attached for record.

**Healthcare Provider
(Authorized Person)
Signature:** _____

**Healthcare Provider
Chop:** _____

**Healthcare Provider
(Authorized Person)
Name:** _____

Date : _____



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