

## Consent of Sharing Health Care Vouchers between Voucher Recipients in Spousal Relationship

To: (Name of the Enrolled Health Care Provider) \_\_\_\_\_

The Director of Health, the Government (“**Government**”) of the Hong Kong Special Administrative Region of the People’s Republic of China (“**Hong Kong**”)

**Please read the Important Notes on page 3 carefully before completing this document.**

1. We, the undersigned, hereby declare that we are in a spousal relationship under marriage recognized by the laws of Hong Kong<sup>Note (a)</sup>.
2. We hereby give consent (“**Consent to Shared Use**”) that when either of our eHealth (Subsidies) Accounts has no more health care vouchers (“**Vouchers**”), any Vouchers remaining in the other of our eHealth (Subsidies) Accounts may be used by either of us.
3. We also give consent to transfer and release to any Enrolled Health Care Provider providing services to either of us, the Government, its agents, or other persons authorised by the Government our personal data<sup>Note (b)</sup> for the use by the Government for the purposes as set out in the Appendix – “Statement of Purpose”.
4. We further give consent, after our respective eHealth (Subsidies) Accounts are paired up, to reveal the balance of Vouchers in our respective eHealth (Subsidies) Account to one another for the purpose of facilitating each other’s advanced planning of the use of Vouchers.
5. This document shall be governed by and construed in accordance with the laws of Hong Kong and we shall irrevocably submit to the exclusive jurisdiction of the courts of Hong Kong.
6. We declare that all information provided in this document is true, accurate and complete. We understand that if we knowingly or wilfully make any false statement, withhold any information or otherwise mislead the Government for the purpose of sharing the Vouchers in our eHealth (Subsidies) Accounts, we will be liable for prosecution. We fully understand our obligations and liability under this document.
7. The “Important Notes” and the Appendix form part of this document.
8. \*We have read this document carefully and have agreed to the content of this document.  
\*(For illiterate voucher recipient(s)) This document has been read over and explained to \*us/  
\_\_\_\_\_ (name of the voucher recipient who is illiterate) and we have agreed to the content of this document.  
\*(For mentally incapacitated voucher recipient(s)) This document has been read and completed by the respective guardian of the voucher recipients who are mentally incapacitated./ I,  
\_\_\_\_\_ (name of the voucher recipient who is not mentally incapacitated), have read this document carefully and have agreed to the content of this document. This document has been read and completed by the guardian of \_\_\_\_\_ (name of the voucher recipient who is mentally incapacitated).
9. The Consent to Shared Use is provided by us vide this document because either one of us is or both of us are mentally incapacitated, or one of us cannot attend an Enrolled Health Care Provider’s place of practice in person to provide such consent. The reason for such absence is:  
\*  physical impairment/immobility  
 bedriddenness  
 other exceptional situation (please specify: \_\_\_\_\_).

**Signature of voucher recipient 1:****Signature of voucher recipient 2:**

\_\_\_\_\_  
 (or finger print if illiterate. Please complete box (A).)  
 (or leave blank if mentally incapacitated. Please complete box (B).)

\_\_\_\_\_  
 (or finger print if illiterate. Please complete box (A).)  
 (or leave blank if mentally incapacitated. Please complete box (B).)

**Name of voucher recipient 1:****Name of voucher recipient 2:**

\_\_\_\_\_  
**\*Hong Kong Identity Card No./  
 Serial No. of the Certificate of Exemption:**

\_\_\_\_\_  
**\*Hong Kong Identity Card No./  
 Serial No. of the Certificate of Exemption:**

**Telephone No.** <sup>Note (c).</sup> \_\_\_\_\_

**Telephone No.** <sup>Note (c).</sup> \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**(A) Complete only if voucher recipient 1 has mental capacity but is illiterate**

I have read this document to voucher recipient 1.  
 I give consent to transfer and release to any Enrolled Health Care Provider providing services to voucher recipient 1 (or to voucher recipient 2), the Government, its agents, or other persons authorized by the Government my personal data for use by the Government for the purpose as set out in the Appendix "Statement of Purpose".

Signature of witness: \_\_\_\_\_  
 Name of witness: \_\_\_\_\_  
 Hong Kong Identity Card No.: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_  
 Date: \_\_\_\_\_

**(A) Complete only if voucher recipient 2 has mental capacity but is illiterate**

I have read this document to voucher recipient 2.  
 I give consent to transfer and release to any Enrolled Health Care Provider providing services to voucher recipient 2 (or to voucher recipient 1), the Government, its agents, or other persons authorized by the Government my personal data for use by the Government for the purpose as set out in the Appendix "Statement of Purpose".

Signature of witness: \_\_\_\_\_  
 Name of witness: \_\_\_\_\_  
 Hong Kong Identity Card No.: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_  
 Date: \_\_\_\_\_

**(B) Complete only if voucher recipient 1 is mentally incapacitated**

I have read this document to voucher recipient 1.  
 I give consent to transfer and release to any Enrolled Health Care Provider providing services to voucher recipient 1 (or to voucher recipient 2), the Government, its agents, or other persons authorized by the Government my personal data for use by the Government for the purpose as set out in the Appendix "Statement of Purpose".

Signature of guardian: \_\_\_\_\_  
 Name of guardian: \_\_\_\_\_  
 Hong Kong Identity Card No.: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_  
 Date: \_\_\_\_\_

**(B) Complete only if voucher recipient 2 is mentally incapacitated**

I have read this document to voucher recipient 2.  
 I give consent to transfer and release to any Enrolled Health Care Provider providing services to voucher recipient 2 (or to voucher recipient 1), the Government, its agents, or other persons authorized by the Government my personal data for use by the Government for the purpose as set out in the Appendix "Statement of Purpose".

Signature of guardian: \_\_\_\_\_  
 Name of guardian: \_\_\_\_\_  
 Hong Kong Identity Card No.: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_  
 Date: \_\_\_\_\_

***\*Delete the inapplicable***

Note (a): For the purpose of this document, two voucher recipients are in a spousal relationship if they are married under monogamous marriage to one another as recognized by the laws of Hong Kong. For the purpose of this document, "monogamous marriage" means a marriage which was —

- (a) if it took place in Hong Kong —
  - (i) celebrated or contracted in accordance with the provisions of the Marriage Ordinance (Chapter 181 of the laws of Hong Kong);
  - (ii) a modern marriage validated by section 8 of the Marriage Reform Ordinance (Chapter 178 of the laws of Hong Kong) and registered under Part IV of that Ordinance; or
- (b) if it took place outside Hong Kong, celebrated or contracted in accordance with the law in force at the time and in the place where the marriage was performed and recognized by such law as involving the voluntary union for life of one man and one woman to the exclusion of all others.

Voucher recipients using this document must read the "Important Notes" on page 3 carefully and must confirm their full understanding of their obligations and liability under this document.

Note (b): Personal data includes all information as shown on the voucher recipients' latest Hong Kong Identity Card (or Certificate of Exemption, if applicable) spousal relationship, telephone number and balance of Vouchers in the eHealth (Subsidies) Account of the voucher recipients.

Note (c): Please provide a Hong Kong mobile phone number which can receive SMS. The voucher recipients/ the guardian(s) of the voucher recipient(s) (as the case may be) will be notified, by SMS at the mobile phone number provided, the amount of Vouchers used for services provided by an Enrolled Health Care Provider.

## **Important Notes**

1. This document is to be used only when either one is or both of the voucher recipients are mentally incapacitated, or either one of the voucher recipients is unable to attend an Enrolled Health Care Provider's place of practice to give his/her consent to pair up their eHealth (Subsidies) Accounts for sharing their Vouchers when there are no more Vouchers remaining in either one's eHealth (Subsidies) Account.
2. In completing this document for provision to an Enrolled Health Care Provider at its place of practice, the voucher recipients should note the following:
  - (a) both voucher recipients are regarded as having agreed that, so long if there are no more Vouchers remaining in a voucher recipient's eHealth (Subsidies) Account, any amount of Vouchers remaining in the eHealth (Subsidies) Account of the other voucher recipient having given the Consent to Shared Use may be used by the first-mentioned voucher recipient for services provided by the Enrolled Health Care Provider to the first-mentioned voucher recipient;
  - (b) both voucher recipients are regarded as having agreed that, for the purpose of facilitating each other's advanced planning of the use of Vouchers referred to in paragraph 2(a) above, the balance of Vouchers in their respective eHealth (Subsidies) Account may be revealed to one another; and
  - (c) if either one is or both of the voucher recipients are illiterate, a witness who must have attained 18 years of age shall sign at the relevant box (A) of this document; or
  - (d) if either one is or both of the voucher recipients are mentally incapacitated, a guardian who must have attained 18 years of age shall sign at the relevant box (B) of this document.
3. A copy of the latest Hong Kong Identity Card (or Certificate of Exemption, if applicable) of the voucher recipient who is unable to attend an Enrolled Health Care Provider's place of practice must be attached to this document for the other voucher recipient with whom the first-mentioned voucher recipient is in a spousal relationship for provision at an Enrolled Health Care Provider's place of practice.
4. The voucher recipients completing this document may be requested by the Government to provide supporting documents (e.g. marriage certificate) to verify their spousal relationship. Any failure to provide supporting documents if requested, and any suspected false, incomplete and/or misleading information provided under this document and/or in response to such request, will be referred to the law enforcement agency for investigation.
5. The Consent to Shared Use given under this document remains effective until:
  - (a) the death of one of the voucher recipients;
  - (b) the marriage between the voucher recipients no longer exists;
  - (c) the voucher recipients' eHealth (Subsidies) Accounts are no longer paired up;
  - (d) the voucher recipient's notice to the Government to withdraw the Consent to Shared Use given under this document; or
  - (e) any false, incomplete and/or misleading information is provided under this document.

## Statement of Purpose

### Purposes of Collection

1. The personal data provided will be used by the Government for one or more of the following purposes:
  - (a) the administration and monitoring of the Health Care Voucher Scheme, including verification by electronic means of the personal data obtained with the database of the Immigration Department;
  - (b) allowing the voucher recipients of eHealth (Subsidies) Accounts which are paired up to reveal to one another the Voucher balance in their respective eHealth (Subsidies) Accounts for the purpose of facilitating their advanced planning of the use of Vouchers;
  - (c) assessing the entitlement to additional vouchers (“Reward”);
  - (d) processing the payment of Vouchers and Reward, if any;
  - (e) for statistical and research purposes; and
  - (f) any other legitimate purposes as may be required, authorized or permitted by law.
2. The provision of personal data is voluntary. If the voucher recipients, (if applicable) the witness(es) and (if applicable) guardian(s) do not provide sufficient information, the voucher recipients may not be able to share the Vouchers in their eHealth (Subsidies) Account with one another.

### Classes of Transferees

3. The personal data provided in this document are mainly for use within the Government but may also be disclosed by the Government to other organizations for the purposes stated in paragraph 1 above, if required.

### Access to Personal Data

4. The voucher recipients, (if applicable) witness(es) and (if applicable) guardian(s) have a right to request access to and correction of the personal data provided under this document pursuant to sections 18 and 22, and Data Protection Principle 6, Schedule 1 of the Personal Data (Privacy) Ordinance (Chapter 486 of the laws of Hong Kong). A fee may be imposed for complying with a data access request.

### Enquiries

5. Enquiries concerning the personal data provided, including the making of access and corrections, should be addressed to:

Executive Officer  
Health Care Voucher Division  
Department of Health  
Suites 901-4, 9/F, AXA Tower, Landmark East  
100 How Ming Street  
Kwun Tong, Kowloon  
Telephone No.: 3582 4102