This authorisation form is to be filled in electronically via the eHRSS, hence printed and signed. The completed and duly signed form has to be submitted together with other supporting documents to the SCPPP Programme Office.

Appendix B

AUTHORISATION FORM FOR PAYMENT OF SUBSIDY TO A SPECIFIED BANK ACCOUNT

Authorisation for Payment of Subsidy for the Pilot Public-Private Partnership Programme on Smoking Cessation ("SCPPP") to a Specified Bank Account

Enrolment reference number*: ***SCP12345***

*(*This number is generated by the system automatically.)*

Note: Please fill in and submit separate Authorisation Forms for Payment of Subsidy to a Specified Bank Account (Appendix B) if you intend to use different bank accounts for different Health Care Institutions, whether or not the Health Care Institutions belong to the same or different Health Care Provider(s).

1. Health Care Institution's Name and Address:

Name: ABC Medical Centre

Address: 10/F, Healthy Building, Healthy Road, Wai Chai, Hong Kong

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Part 1 - Bank Details (Note (a))

Bank: Hong Kong Bank

Branch: Wan Chai

Bank Account Number (Notes (b) and (c))

Bank Code			Branch Code			Account No.								
0	0	1	0	0	2	1	2	3	4	5	6	7		

Bank Account Name in English

A	B	C		M	E	D	I	C	A	L		C	E	N	T	R	E										

Part 2 - Declaration

By submitting this Authorisation Form for Payment of Subsidy to a Specified Bank Account (Appendix B) ("Authorisation Form"), I/we hereby agree that:

1. the acknowledgement by the bank specified in Part 1 of the Authorisation Form above ("Specified Bank") to the Government of the Hong Kong Special Administrative Region ("Government") of receipt of any sum paid by the Government into the bank account specified in Part 1 of the Authorisation Form above ("Specified Account") shall be a sufficient discharge in lieu of any acknowledgement by me/us of such payment of subsidy by the Government under the SCPPP;

2. nothing in this Authorisation Form shall give rise to any obligation on the Government to make any payment into the Specified Account or to settle any sum that may be payable by the Government to me/any of us by payment into the Specified Account, whether under the SCPPP or otherwise;

3. where, for any reason, insufficient, inaccurate or incomplete information is furnished by me/us to the Specified Bank to determine the Specified Account to be credited and any sum is held in suspense pending receipt of further or more particular information from me/us, the Government shall not be liable or responsible for any loss, inconvenience or expenses that may be suffered or incurred by me/us as a result of the Specified Account not being credited at the time when a payment is made, or attempted to be made, by the Government into the Specified Account; and

4. I/We undertake(s) to refund to the Government any over-payment received by me/us from the Government under the SCPPP as soon as reasonably practicable at any time upon demand or request by the Government.

By the Applicant	**By the Health Care Provider ("HCP")**
Chan Signature	Official Stamp  Yee Authorised signature(s) (for and on behalf of the HCP)

Name of Applicant in block letters: CHAN TAI MAN

(as shown on the Hong Kong Identity Card):

Hong Kong Identity Card No.: A123456(7)

Telephone no.: 23456789

Date: 1 Jul 2018

Name of HCP: ABC Medical Centre

Name(s) and position(s) of authorised signatory(ies) in block letters: LEUNG SIU YEE, Secretary

Telephone no.: 23456789

Date: 1 Jul 2018

NOTES:

(a) When submitting this Authorisation Form, please provide a certified true copy of bank correspondence(s) (e.g. bank statement) showing the name of the bank, bank account number and the full name of the account holder of the specified account(s) for payment of the subsidy as set out in Part 1 of the Authorisation Form. If the bank correspondence relates to the Applicant, the copy thereof must be certified to be true and complete by the Applicant. If the bank correspondence relates to the Health Care Provider, the copy must be certified to be true and complete by the authorised signatory(ies) of the Health Care Provider appearing in Part 2 of this Authorisation Form.

(b) In completing Part 1 of the Authorisation Form, please do not use one space for more than one letter or one digit. Where a complete word cannot be entered at the end of a row because of insufficient space, the whole word should be entered in the next row.

(c) If you do not know the bank code and/or branch code of your bank account, please contact the relevant bank.

Personal Information Collection Statement

Statement of Purpose

Purposes of Collection

(1) Any information, including the personal data provided to the Government in connection with any application for enrolment in the SCPPP will be used by the Government for one or more of the following purposes:
   (a) processing the application for enrolment in the SCPPP including but not limited to a verification procedure with data kept by The Medical Council of Hong Kong;
   (b) administration, monitoring, auditing and evaluation of the SCPPP including but not limited to processing subsidy payment, providing necessary health care service and continuity of care to participant, and investigation of incidents and complaints;
   (c) statistical, programme monitoring, evaluation and research purposes; and
   (d) any other legitimate purposes as may be required, authorised or permitted by law.

(2) The provision of any information, including the personal data is voluntary. However, if you do not provide sufficient information, we may not be able to process your application.

Classes of Transferees

(3) The personal data you provide are mainly for use within the Government but they may also be disclosed by the Government to other persons, organisations, professional regulatory boards and councils, and third parties for any of the purposes stated in paragraph (1) above, if required.

Access to Personal Data

(4) You have a right to request access to and correction of your personal data under sections 18 and 22 and Data Protection Principle 6, Schedule 1 of the Personal Data (Privacy) Ordinance (Cap. 486). A fee may be imposed for complying with a data access request.

Enquiries

Enquiries concerning the personal data provided, including the making of access and correction, should be addressed to the following officer of the Department of Health:

Executive Officer
Primary Care Office, Department of Health
Room 1008, 10/F, Guardian House, 32 Oi Kwan Road, Wan Chai, Hong Kong
Tel no.: 3576 3658