

SCPPP Participant No. : 00000001

(Auto-filled by the System)

**DEPARTMENT OF HEALTH  
PILOT PUBLIC PRIVATE PARTNERSHIP PROGRAMME ON SMOKING CESSATION  
PARTICIPANT CONSENT FORM**

Note : Please complete this consent form using black or blue pen.

Please read the “Undertaking and Declarations” before you sign this form.

**Personal particulars of Participant :**


Chinese Name : 陳小文	
English Name : CHAN SIU MAN	
Hong Kong Identity Card (HKIC) No.: B123456(7)	
Electronic Health Record Sharing System (eHRSS) No.: 9684-0274-7626	
Date of birth: 01-Jan-1946	Sex: Male

I have read carefully this Consent Form including its “Undertaking and Declarations”, and fully understood my obligation and liability. I agree to the contents contained therein.

I confirm that I have enrolled in the eHRSS. I hereby consent to participate in the Pilot Public Private Partnership Programme on Smoking Cessation (SCPPP).

I AGREE to be approached by research institutions for research related to smoking cessation and for this purpose, I consent and authorize the Government to disclose my name and contact telephone number to the research institutions concerned.

I DO NOT agree to be approached by research institutions for research related to smoking cessation.

Signature of Participant (or finger print if illiterate): 

Date of enrolment: 01-Aug-2018

**Complete only if the Participant is illiterate :**

This document has been read and explained to the Participant in my presence.

\_\_\_\_\_  
Name of witness

\_\_\_\_\_  
HKIC No. of witness

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

**Information of Enrolled Doctor :**

CHAN, TAI MAN  
9876543211

**DEPARTMENT of HEALTH**  
**PILOT PUBLIC PRIVATE PARTNERSHIP PROGRAMME FOR SMOKING CESSATION**  
**PARTICIPANT CONSENT FORM**

**Undertaking and Declarations**

1. Under the Pilot Public Private Partnership Programme on Smoking Cessation (“SCPPP”), I understand that:-
  - a. clinical care will be provided by Enrolled Doctors in the SCPPP;
  - b. the Enrolled Doctors shall be professionally accountable for all related clinical care and management. The Government bears no responsibilities and obligations in this context;
  - c. the Enrolled Doctors will claim reimbursement of subsidies for having provided the smoking cessation service under the SCPPP administrated by the Department of Health (DH).
2. I hereby agree to transfer and release my personal data to the Government, its agents, or other persons authorized by the Government for the use by the Government for the purposes as set out in the “Statement of Purpose”. My personal data includes:-
  - (a) my HKIC number, name (in English and Chinese), sex, date of birth, date of issue of HKIC,
  - (b) my contact telephone number refer to those captured under the eHRSS, and
  - (c) any information (including but not limited to the clinical information) related to the SCPPP.
3. I note that the Government may contact me by calling my contact telephone number for the purposes as set out in the “Statement of Purpose”.
4. I agree to authorize the Enrolled Doctors to read my personal data stored in the chip embodied in the HKIC for the purposes as set out in the “Statement of Purpose”.
5. I agree to give indefinite sharing consent to the Enrolled Doctor in order to receive continuing care throughout the smoking cessation pathway.
6. I agree that my personal data and any information collected and stored in the Smoking Cessation Information Technology System under the SCPPP will be transferred onto the eHRSS for access by healthcare providers whom I have given consent under the eHRSS.
7. I understand this consent (including these Undertaking and Declarations) shall be governed by and construed in accordance with the laws of Hong Kong Special Administrative Region and I, and the Government shall irrevocably submit to the exclusive jurisdiction of the Hong Kong Special Administrative Region.
8. I have read this consent (including these Undertaking and Declarations) carefully and fully understood my obligations and liability under this consent.  
(For illiterate Participant: This consent including these Undertaking and Declarations has been read over and explained to me and I fully understand my obligations and liability.)
9. I declare that the information provided in this Consent Form is factually correct.
10. I understand that I should observe the Prevention of Bribery Ordinance (Cap. 201) and should not offer to, solicit or accept from any person any advantage as defined in the Ordinance.

## Statement of Purpose

### *Purpose of Data Collection*

1. Any information, including the personal and clinical data as well as contact details provided under the SCPPP will be used by the Government for one or more of the following purposes:
  - a. Processing the enrollment of Participant to the SCPPP, including but not limited to a verification procedure with the data kept by the Immigration Department;
  - b. Administration, monitoring, auditing and evaluation of the SCPPP including but not limited to processing subsidy payment, and investigation of incidents and complaints;
  - c. Statistical, programme monitoring, evaluation and research purposes; and
  - d. Any other legitimate purposes as may be required, authorized or permitted by law.
2. The provision of any information, including the personal data is voluntary. However, if insufficient information is provided, the Participant may not be able to participate in the SCPPP.

### *Classes of Transferees*

The personal data provided by the Participant are mainly for use within the Government but they may also be disclosed by the Government to other persons, organizations, and third parties for any of the purposes stated in paragraphs (a) to (d) above, if required.

### *Access to Personal Data*

The Participant has a right to request access to and correction of his/her personal data under sections 18 and 22 and Data Protection Principle 6, Schedule 1 of the Personal Data (Privacy) Ordinance (Cap. 486). The Department of Health may impose a fee for complying with a data access request.

### *Enquiries*

Enquiries regarding the personal data provided, including the making of access and corrections, should be addressed to:-

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