CHINESE HOSPITAL & CLINICS

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

提供醫療資料授權

Patient Name 病人姓名 _____

ID/SSN 証件/社安號碼 _____

Date of Birth 出生日期 _____

Address 地址 _____

City 城市 _____

State 州 _____ Zip Code 郵區號碼 _____

Phone Number 電話 _____

Email 電子郵件 _____

Chinese Hospital will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.
東華醫院將不會因為在提供或拒絕授權醫療資料的情況下，而對任何人仕作出有限制的治療、收費、及合理權益。

I hereby authorize:
本人特此授權：

Chinese Hospital

Name of Disclosing Party 提供資料公司的名稱

845 Jackson St, San Francisco, CA 94133

Address 地址 City 城市 State 州 Zip Code 郵區號碼

to disclose to:
透露予：

Name of Recipient 收件人名稱

Address 地址 City 城市 State 州 Zip Code 郵區號碼

records and information pertaining to: 有關記錄和資料:

☐ Medical/Hospital Records 醫療/入院記錄 dated from 日期由 _____ to 至 _____

☐ Medical Record Number 醫療記錄 _____

☐ Billing Records 帳單記錄 dated from 日期由 _____ to 至 _____

☐ Other (records specially limited to) 其他(列明具體限制之記錄) _____

The recipient may use the health information authorized on this form for the following purpose: 收件人獲得授權使用此份醫療資料；可用在下列用途：

☐ at the request of the individual 個別請求

☐ other (use specifically limited to) 其他(列明具體限制之用途) _____

DURATION: 期限

This authorization is effective for one year unless a different date is specified here _____. 此份授權書的有效期是一年，除非在此欄列明其他日期_____。

REVOCATION: 撤消:	You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request. 閣下或您的代表可用書面申請撤消此份授權書。但在收到這撤消通知前已披露的醫療資料將不會備受影響。
REDISCLOSURE: 再提供給第三者:	Once this health information is disclosed, how the recipient further discloses it may no longer be protected under state or federal law. 一旦此健康資料提供後，接受這資料人仕如何使用這資料及作任何用途，可能不再受州政府或聯邦私隱法律的保護。
PERSONAL USE: 個人用途:	I understand that I may be charged a per page fee for copies produced for my personal use.我明白我可能要支付復制每頁副本的費用作為個人使用的原因收費。

If a **health plan** or **healthcare provider** requested this authorization, will it receive financial or in-kind compensation in exchange for using/disclosing such information?
☐ No ☐ Yes (if Yes, please describe) _____

A copy of this authorization is as valid as an original. I understand that I have the right to receive a copy of this authorization. I understand that this authorization is voluntary. 此授權書的副本如正本一樣有效 。本人有權獲得受授權書的副本 。本人瞭解此授權書屬自願性 。

X

Signature 簽名 **Date 日期**

If signed by other than member/patient, indicate relationship:
如果由其他成員/非病人簽署，請填寫關係: _____

ADDITIONAL SIGNATURE IS REQUIRED IF REQUESTING ANY OF THE FOLLOWING:
如要求使用下列資料，必需簽名確定:

☐ Mental Health 心理健康狀況 dated from 日期由 _____ to 至 _____
☐ Alcohol/Drug 酒精/藥物 dated from 日期由 _____ to 至 _____
☐ HIV Test 愛滋病毒抗體測試 dated from 日期由 _____ to 至 _____

Signature 簽名: _____ Date 日期: _____

Delivery Preference 交收方式選擇
☐ Pickup 取件 ☐ Mail 郵寄
☐ Email (secure) 電子郵件 _____
☐ Fax 傳真 _____

Official Use Only			
Date Received		Date Copies needed by	
Date Processed		Date Picked-up	