



**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 _____
 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 _____
 Medical Record Number 醫療記錄號碼 _____

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，而對任何人作出有限制的治療、收費、及合理權益。

I hereby

authorize:

本人特此授

權:

Name of Disclosing Party 提供資料公司的名稱

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 _____
- 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) _____
- Online Patient Portal Access Only/ Email 電子郵件 _____

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_____。

REVOCAATION: 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.
撤消: 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。

REDISCLASURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under state or federal law.
再提供給第三者: 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: I understand that I may be charged a per page fee for copies produced for my personal use.
個人用途: 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	
<input type="checkbox"/> Pickup 取件	<input type="checkbox"/> Mail 郵寄
<input type="checkbox"/> Email (secure) 電子郵件 _____	
<input type="checkbox"/> Fax 傳真 _____	

Media Type 交收類型
Electronic 電子傳遞
Paper 紙張

Official Use Only
Date Processed
Date Picked-up