KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

MR #: ______

Name: ______

IMPRINT AREA

使用和/或透露會員/病人健康資訊授權書 / AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

我瞭解，Kaiser Permanente 不會因為本人提供或拒絕提供這項授權，而限制本人接受治療、付款、加入或成為會員的權益。

我在此授權 / I hereby authorize:

透露方姓名 / Name of Disclosing Party

地址 / Address

市鎮 / City　州 / State　郵遞區號 / ZIP

可透露資訊給 / to disclose to:

接收者姓名 / Name of Recipient

地址 / Address

市鎮 / City　州 / State　郵遞區號 / ZIP

如您要索取自己的病歷記錄，請指定機構 / If requesting your own records for yourself, specify facilities ______

索取下列會員/病人的相關記錄與資訊 / Records and information pertaining to:

會員/病人姓名 (列出所用的其他名稱) / Name of Member/Patient (List Other Names Used)

醫療記錄號碼 / Medical Record Number

出生日期 / Date of Birth

地址 / Address

電話號碼 / Telephone No.

有效期： 本授權會立即生效，且除非本文件中另外指定其他日期 ______ (日期)，否則在簽名日期後一年內保持有效。

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here ______ (Date).

撤銷： 會員/病人有權利隨時以書面通知書撤銷此授權。撤銷於接獲書面通知時即生效，但撤銷前透露資訊的一方或其他人根據該授權採取行動者不在此限。

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

重新透露： 我瞭解，除非獲得本人重新授權，或法律上特別要求或許可，否則，接收資訊的一方進一步使用或透露本人健康資訊皆屬違法。

REDIS-CLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

01782-002 (REV. 9-08) HIPAA COMPLIANT
FOR ENGLISH USE 90258, SPANISH 01782-000

DISTRIBUTION: WHITE = CHART • CANARY = MEMBER/PATIENT

FORM NOT TO BE USED FOR RESEARCH

MR #: ______

Name: ______

IMPRINT AREA

指定記錄： 勾選方塊、註明姓名縮寫和/或簽名，以指定要透露的資訊類型。

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

☐ **醫療資訊 / MEDICAL INFORMATION** ______ (姓名縮寫 / Initial)

☐ **心理資訊 / PSYCHIATRIC INFORMATION** 簽名 / Signature ______ 日期 / Date ______

☐ **藥物/酒精資訊 / DRUG/ALCOHOL INFORMATION** 簽名 / Signature ______ 日期 / Date ______

☐ **HIV 測試結果 / RESULTS OF AN HIV TEST** 簽名 / Signature ______ 日期 / Date ______

☐ **家族遺傳記錄 / GENETIC RECORDS** 簽名 / Signature ______ 日期 / Date ______

指定要透露的記錄 / Specify the records to be disclosed: ______

接收方可將本授權書所授權的健康資訊用於下列用途 / The recipient may use the health information authorized on this form for the following purposes:

本授權書副本與正本效力相同。 / A copy of this authorization is as valid as the original.

會員/家長有權索取此授權書的副本。 / Member/Patient has a right to a copy of this authorization.

日期 / Date　簽名 / Signature

若簽名者非會員/病人本人，請說明與會員/病人之關係 / If Signed by Other than Member/Patient, Indicate Relationship

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