SWEDISH

使用、披露和發佈受保護健康資訊授權書
AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION (CHINESE TRADITIONAL)

我已瞭解以下內容：
I understand the following:

- 我有權拒絕簽署披露或發佈我的受保護資訊的授權書。拒絕簽署此授權書不會對我接受醫療保健服務或償付服務的能力產生不利影響。拒絕簽署此授權書可能影響我接受醫療保健服務能力的唯一情況為：醫療保健服務與研究相關，或僅向某人提供健康資訊，此時，必須具備授權書以披露資訊。
  I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.

- 此請求可能會產生費用。
  There may be a fee associated with this request.

- 根據此授權書已使用或披露的資訊可能被再次披露且不再受聯邦法律保護。但是，我也瞭解，聯邦或州法律可能限制再次披露 **HIV/AIDS**、心理健康資訊、基因測試資訊和藥物/酒精診斷、治療或轉介資訊。
  Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

- 我有權獲得一份簽署的授權書。
  I have the right to receive a copy of this signed authorization.

- 我可以在任何時間以書面形式撤回此授權書。如果我撤回此授權書，則以下所述資訊可能不再適用或不再出於此書面授權書所述之目的進行披露。唯一例外情況為：**Swedish** 已根據此授權書採取措施或將此授權書作為提供保險承保的條件。
  I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when Swedish has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

請向其中一個地點提交此授權書或撤銷授權書，具體取決於您接受服務的地點：
Please submit this authorization or revocation to one of these locations, depending on where you received care:

Swedish Medical Center	**Swedish Medical Group**
Release of Information Department 747 Broadway, Seattle, WA 98122 傳真/Fax: (206) 320-2626 電郵/Email: ROI@swedish.org	電話/Phone: (206) 320-3025 傳真/Fax: (478) 238-9436 電郵/Email: smgroi-wa@cioxhealth.com

重要事項：除非有開具帳單的必要，否則 **Swedish** 不再列印或發佈患者的社會安全號碼。不過，社會安全號碼能包含於若干年前的患者資訊中。您授權使用的資訊可能包括您的社會安全號碼。
Important: Swedish no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

本機構、其員工、官員和醫師據此免於承擔因披露以上資訊（在此授權書指定和授權的範圍內）而產生的任何法律責任。

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The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Swedish Health Services 及其附屬機構不會以種族、膚色、原國籍、性別、年齡或殘障情況而在他們的健康計劃及活動中歧視任何人。

Swedish Health Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

請注意：如果您不會說英語，您可以使用免費的翻譯服務。請致電（888）311-9127（TTY：711）。

ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127(TTY: 711).

我授權 **Swedish** 使用和披露以下具體健康資訊：

患者姓名/Patient's Name _____ 出生日期/DOB: _____

患者住址/Patient's Address: _____ 電話/Phone: _____

城市/City: _____ 州/State: _____ 郵遞區號/Zip Code: _____

接收披露資訊方： ☐ 自己 Self 或接收者姓名： _____
To be disclosed to: Or Recipient's Name:

接收者住址： _____
Recipient's Address:

城市/City: _____ 州/State: _____ 郵遞區號/Zip Code: _____

電話/Phone: _____ 傳真/Fax: _____ 電郵/Email: _____

透過以下方式發送我的記錄： ☐ MyChart MyChart ☐ 電郵 Email ☐ 磁碟 Disc ☐ 紙本 Paper ☐ 傳真 Fax
Please send my records via:

我希望從以下機構索求資訊：
I am requesting information from the following facility(s):

醫院名稱 （清單）和電話號碼 Hospital Name (List) & Phone Number	診所名稱 （清單）和電話號碼 Clinic Name (List) & Phone Number

使用日期從： _____ 至： _____
For the range of dates from: to:

用於以下診斷或傷害的相關資訊： _____
For information related to the following diagnosis or injury:

_____

允許披露的資訊/Information to be disclosed:

☐病史和體檢/History & Physical

☐手術報告/Operative Report

☐診斷報告 （化驗室化驗、x 光、 **EKG** 等）
Diagnostic Reports (lab, x-ray, EKG, etc.)

☐出院摘要或醫囑/Discharge Summary

☐急診科報告/Emergency Department Report

☐進展記錄/Progress Notes

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☐其他（請說明)/Other (specify):_____

基於此目的：_____
For the purpose of:

除撤回外，此授權書有效期為 **180** 天或在此日期失效：_____
Unless revoked, this authorization expires in 180 days or on this Date:

條款：除非我本人以書面形式明確對此授權書進行限制，否則，此授權書涵蓋測試和/或治療性傳播疾病、**AIDS**、**HIV** 感染、酒精和/或藥物濫用、心理健康狀況或其他敏感資訊。
Terms: This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

患者簽名：_____日期/Date:_____
Patient Signature: （工整書寫及手寫簽名）
(Print form and sign by hand)

患者代理人姓名:_____日期/Date:_____
Patient Representative Name:

患者代理人姓名:_____
Patient Representative Signature: （工整書寫及手寫簽名。請附上證明文件。）
(Print form and sign by hand. Please include supporting documentation.)

與患者關係:_____
Relation to Patient: