3600

Providence SWEDISH

患者存取/披露指定记录集申请表

Patient Request to Access/Disclose a Designated Record Set (Simplified Chinese))

完成此文件即表示授权披露和/或使用关于您的健康信息。未能提供所要求的所有信息可能会使此授权无效。 Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

注意：如果您是患者/患者代表，为个人用途申请医疗记录，我们可能会收取医疗记录制作费。/ NOTE: If you are a patient/patient representative requesting medical records for personal use, there may be a fee for production of the medical records.

本患者存取/披露指定记录集申请表基于州和联邦法规的规定要求提供信息。/ Information requested in this Patient Request to Access/Disclose a Designated Record Set is based on requirements by both state and federal regulations.

如若申请表上空间不够，您可以另附页。 You may attach an additional page if more room is needed than provided on the request form.

如果您是为已故患者申请记录，请提交死亡证明复印件；如有，还请提交委托书、信托书或遗嘱的复印件；申请医疗记录者的驾照以及填妥的申请表。 If you are requesting records for a deceased patient, please submit a copy of the death certification; copy of Power of Attorney, trust or will, if available; driver's license of person requesting medical records; along with the completed request form.

请将此表格转寄至： Please forward this form to:

仅医院医疗记录申请：

Swedish 医疗中心
Release of Information Department
747 Broadway, Seattle, WA 98122
电子邮件：ROI@swedish.org
电话：(206) 320-3850 • 传真：(206) 320-2626

仅 Swedish 医疗集团 (Swedish Medical Group) 申请：

电子邮件：smgroi-wa@datavant.com
电话：(206) 320-3025 • 传真：(478) 238-9436

请注意：除非有开具账单的必要，否则 Swedish 医疗中心 (Swedish Medical Center, SMC)/Swedish 医疗集团 (Swedish Medical Group, SMG) 不再打印或披露患者的社会保险号。但是，社会保险号可能包含于若干年前的医疗记录中。/ Please Note: SMC/SMG no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in medical records that are more than a few years old.

您所请求的医疗记录可能因州法律的留存要求而无法提供。 Medical Records you are requesting may not be available due to the state retention requirements.

根据本授权书披露的信息可能会被接收方再次披露。在某些情况下，此类再次披露不受州法律保护，也可能不再受联邦保密法健康保险流通与问责法案 (Health Insurance Portability and Accountability Act, HIPAA) 保护。 Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

注意：如果您不会讲英语，您可以自由决定使用免费的语言协助服务。请致电 888-311-9127（Swedish 埃特蒙德 (Edmonds) 院区 电话：888-311-9178）(TYY: 711)。

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中文翻譯服務, 請致電 888-311-9127 (TYY: 711)

患者存取/披露指定记录集申请表

PATIENT REQUEST TO ACCESS/DISCLOSE A DESIGNATED RECORD SET (SIMPLIFIED CHINESE)

说明：EXPLANATION:

我们要求您提供此授权旨在遵守州及联邦相关规定。

患者姓名 Patient's Name：	出生日期： Date of Birth:	
曾用名： Prior Name(s) Used:	电话号码： Phone #:	
患者住址： Patient's Address:		
城市： City:	州： State:	邮政编码： Zip Code:
电子邮件地址：Email Address:_____@_____		

健康信息的使用与披露：USE AND DISCLOSURE OF HEALTH INFORMATION:

本人特此授权 **SMC/SMG** 将我的医疗记录披露给以下人员： I hereby authorize SMC/SMG to release my medical records to:

☐ 本人或 (Myself) ☐ 下方列出的接收方：(Recipient listed below):

接收方姓名： Recipient's Name	收件人： Attention:	
接收方地址：Patient's Address		
城市： City:	州： State:	邮政编码： Zip Code:
电话：Phone #:	传真：**Fax:**	
传送选项：Delivery Option: ☐ **MyChart** ☐ 纸质（邮寄）Paper (Mailed) ☐ **CD**（邮寄）CD (Mailed) ☐ 传真**FAX** ☐ 电子邮件 Email：_____@_____		

请求披露的信息：INFORMATION TO BE RELEASED :

本人向以下医院索求信息 I am requesting information from the following Hospital(s)：

列出医院 List Hospital(s)	指明治疗日期 Specify the Dates of Treatment

请求披露的信息（仅勾选本部分中的一个方框）**INFORMATION TO BE RELEASED :**

☐ 相关信息（这是大多数患者和医生需要的信息）。出院摘要、急诊科报告、病史及体格检查、会诊、手术报告、实验室检查、放射学报告、脑电图 **(Electroencephalogram, EEG)**、肌电图 **(Electromyography, EMG)**、心电图 **(Electrocardiogram, EKG)**、病理报告。（可能会收取费用）Pertinent information

☐ 所有/完整医疗记录（包括相关信息以及医疗记录中的所有其他文件）（可能会收取费用）All/Entire Medical Record **(Includes pertinent information plus all other documentation in the medical record)** (A fee may be charged)

☐ 其它（详细说明）Other (specify)：_____

☐ 仅过去两年（请指定打印资料包）Last two years only **(Specify print package)**：

☐ 相关信息 Pertinent Information ☐ 所有/完整医疗记录 All/Entire Medical Record

因州/联邦法规，以下信息需要额外授权：ADDITIONAL AUTHORIZATION REQUIRED:

本人特别授权披露以下信息（请根据需要勾选、首字母草签并注明日期）I specifically authorize release of the following information **(check, initial and date as appropriate)：**

☐ 心理健康治疗信息 Mental Health treatment information	首字母草签并注明日期 Initial and Date：
☐ 人类免疫缺陷病毒 **(Human Immunodeficiency Virus, HIV)** 检测结果 HIV test results	首字母草签并注明日期 Initial and Date
☐ 酒精/药物治疗信息 Alcohol/drug treatment information	首字母草签并注明日期 Initial and Date
☐ 性传播疾病（仅适用于华盛顿州 **(Washington, WA)**） Sexually Transmitted Disease (WA Only)	首字母草签并注明日期 Initial and Date

目的 PURPOSE：

申请使用或披露的目的 Purpose of requested use or disclosure：☐ 患者申请 Patient Request ☐ 继续护理Continuing Care ☐ 法律 Legal ☐ 保险 Insurance ☐ 其他 **Other**：_____

有效期 EXPIRATION：

本授权书的有效期（到期日） This Authorization expires (Date)：_____

如未给出具体日期，则本授权书将在签名日期起六个月后失效。 If no Date is given, this authorization will expire in six months from the signature date.

我的权利 MY RIGHTS：

我有权拒绝签署本授权书。如我拒绝签署本授权书，我应当知晓根据法律规定，我的健康信息不能被披露。我的拒绝不会影响我获得治疗、付款或福利资格的能力。I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

我有权检查或获取我被要求允许使用或披露的健康信息的副本。我可随时撤销本授权书，但必须以书面形式进行，并提交至以下地址：I may inspect or obtain a copy of the health information that I am being asked to allow the use or dis- closure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Providence St. Joseph Health
Health Information Release of Information/Revoke Authorization
P.O. Box 4950
Portland, OR 97208

我的撤销将在接收方收到时生效，但他人已依据本授权书采取行动的情况除外。My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization

我有权收到本授权书的副本。I have a right to receive a copy of this authorization

根据本授权书披露的信息可能会被接收方再次披露。Information disclosed pursuant to this authorization could be re-disclosed by the recipient. 在某些情况下，此类再次披露不受州法律保护，也可能不再受联邦保密法健康保险流通与问责法案 **(Health Insurance Portability and Accountability Act, HIPAA)** 保护。Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

签名 SIGNATURE：

患者签名： Patient Signature:	日期 Date：
法定代表签名： （患者代表/配偶） Legal Representative Signature: (Patient representative/spouse)	日期 Date：

若由非患者本人签署，则需说明您与患者的法律关系，并请提供相关文件，如持久授权书 **(Durable Power of Attorney, DPOA)**、死亡证明、监护权证明的副本：If signed by someone other than the patient, state your legal relationship to the patient and

please provide, i.e, copy of DPOA, Death Certificate, Guardianship:

与患者的关系 Relationship to Patient:	日期 Date：

根据州法规，可能需要获得在患者住院期间为其诊治的医生的授权。

Dependent on State Regulations, authorization from the physician who attended the patient during their stay may be required.

HOSPTIAL USE ONLY

PHYSICIAN RELEASE OF MEDICAL RECORD

☐ APPROVED by Physician Name: _____ Date: _____ HIM-ROI CG Initials: _____

☐ DENIED – REASON FOR DENIAL: _____

MD Signature: _____ Date: _____ Time: _____