3600

Providence SWEDISH

患者存取/揭露指定記錄集申請表
Patient Request to Access/Disclose a Designated Record Set (Chinese Traditional)

完成此文件即表示授權揭露和/或使用關於您的健康資訊。未能提供所要求的所有資訊可能會使此授權無效。 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，為個人用途申請醫療記錄，可能會收取醫療記錄製作費。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/揭露指定記錄集申請表基於州和聯邦法規的規定要求提供資訊。 Information requested in this Patient Request to Access/Disclose a Designated Record Set is based on requirements by both state and federal regulations.

如若申請表上空間不夠，您可以另附頁。 You may attach an additional page if more room is needed than provided on the request form.

如果您是為已故患者申請記錄，請提交死亡證明副本；如有，還請提交委託書、信託書或遺囑的副本，申請醫療記錄者的駕照以及填妥的申請表。 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.

請將此表格轉寄至： Please forward this form to:

僅醫院醫療記錄申請：
Swedish Medical Center
Release of Information Department
747 Broadway, Seattle, WA 98122
電子郵件：ROI@swedish.org
電話：(206) 320-3850 • 傳真：(206) 320-2626

僅瑞典醫療集團 (Swedish Medical Group) 申請：
電子郵件：smgroi-wa@datavant.com
電話：(206) 320-3025 • 傳真：(478) 238-9436

請注意：除非有開具帳單的必要，否則瑞典醫療中心 (Swedish Medical Center, SMC)/瑞典醫療集團 (Swedish Medical Group, SMG) 不再列印或揭露患者的社會安全號。但是，社會安全號可能包含於若干年前的醫療記錄中。 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.

您所請求的醫療記錄可能因州法律的留存要求而無法提供。 Medical Records you are requesting may not be available due to the state retention requirements.

根據本授權書揭露的資訊可能會被接收方再次揭露。在某些情況下，這種再次揭露不受州法律保護，也不再受聯邦保密法健康保險流通與問責法案 (Health Insurance Portability and Accountability Act, HIPAA) 保護。 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：如果您不會講英語，您可以自由決定使用免費的語言協助服務。請致電 888-311-9127（Swedish 埃特蒙德 (Edmonds) 院區電話：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/揭露指定記錄集申請表

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

說明：EXPLANATION:

我們要求您提供此授權旨在讓您遵守州及聯邦相關規定。

患者姓名： Patient's Name:	出生日期： Date of Birth:	
曾用名： Prior Name(s) Used:	電話號碼： Phone #:	
患者地址： Patient's Address:		
城市： City:	州： State:	郵遞區號： Zip Code:
電子郵件地址：Email Address:_____ @ _____		

健康資訊的使用與揭露：USE AND DISCLOSURE OF HEALTH INFORMATION:

本人特此授權 **SMC/SMG** 將我的醫療記錄揭露給以下人員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:	注意： Attention:	
接收方地址：Patient's Address		
城市： City:	州： State:	郵遞區號： Zip Code:
電話：Phone #:	傳真：**Fax:**	

傳送選項Delivery Option： ☐ **MyChart** ☐ 紙質（郵寄）Paper (Mailed) ☐ **CD**（郵寄）CD (Mailed) ☐ 傳真 **FAX**

☐ 電子郵件Email:：_____@_____

請求揭露的資訊 INFORMATION TO BE RELEASED ：

本人向以下醫院索求資訊 I am requesting information from the following Hospital(s)：

列出醫院 List Hospital(s)	指明治療日期 Specify the Dates of Treatment

請求揭露的資訊（僅勾選本部分中的一個選項）**INFORMATION TO BE RELEASED**：

☐ 相關資訊（這是大多數患者和醫生需要的資訊）。出院摘要、急診科報告、病史及體檢、會診、手術報告、實驗室檢查、放射學報告、腦電圖 **(Electroencephalogram, EEG)**、肌電圖 **(Electromyography, EMG)**、心電圖 **(Electrocardiogram, EKG)**、病理報告。（可能會收取費用）Pertinent information

☐ 所有/完整醫療記錄（包括相關資訊以及醫療記錄中的所有其他文件）（可能會收取費用）All/Entire Medical Record **(Includes pertinent information plus all other documentation in the medical record)** (A fee may be charged)

☐ 其它（詳細說明）Other (specify)：_____

☐ 僅過去兩年（請指明列印資料包）Last two years only **(Specify print package)**：

☐ 相關資訊 Pertinent Information ☐ 所有/完整醫療記錄 All/Entire Medical Record

因州/聯邦法規，以下資訊需要額外授權 ADDITIONAL AUTHORIZATION REQUIRED：

我特別授權揭露以下資訊（請根據需要勾選、簽首字母與註明日期）I specifically authorize release of the following information **(check, initial and date as appropriate)：**

☐ 心理健康治療資訊 Mental Health treatment information	首字母簽名與日期 Initial and Date：
☐ 人類免疫缺陷病毒 **(Human Immunodeficiency Virus, HIV)** 檢測結果 HIV test results	首字母簽名與日期 Initial and Date：
☐ 酒精/藥物治療資訊 Alcohol/drug treatment information	首字母簽名與日期 Initial and Date：
☐ 性傳播疾病（僅適用於華盛頓州 **(Washington, WA)**）Sexually Transmitted Disease (WA Only)	首字母簽名與日期 Initial and Date：

目的 PURPOSE：

申請使用或揭露的目的 Purpose of requested use or disclosure: ☐ 患者申請 Patient Request ☐ 繼續照護 Continuing Care ☐ 法律 Legal ☐ 保險 Insurance ☐ 其他 Other：_____

有效期 EXPIRATION：

本授權書的有效期（到期日）This Authorization expires (Date：_____

如未給出具體日期，則本授權書將在簽名日期起六個月後失效。If no Date is given, this authorization will expire in six months from the signature date.

我的權利 MY RIGHTS：

我有權拒絕簽署本授權書。如我拒絕簽署本授權書，我應當知曉根據法律規定，我的健康資訊不能被揭露。我的拒絕不會影響我獲得治療、付款或福利資格的能力。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.

我有權檢查或獲取我被要求允許使用或揭露之健康資訊的副本。我可隨時撤銷本授權書，但必須以書面形式進行，並提交至以下地址 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

我的撤銷將在接收方收到時生效，但他人已依據本授權書採取行動的情況除外。My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

我有權收到本授權書的副本。/ I have a right to receive a copy of this authorization.

根據本授權書揭露的資訊可能會被接收方再次揭露。Information disclosed pursuant to this authorization could be re-disclosed by the recipient. 在某些情況下，這種再次揭露不受州法律保護，也不再受聯邦保密法健康保險流通與問責法案 **(Health Insurance Portability and Accountability Act, HIPAA)** 保護。Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

簽名 SIGNATURE:：

患者簽名： Patient Signature:	日期 Date：
法定代表簽名： （患者代表/配偶） Legal Representative Signature: (Patient representative/spouse)	日期 Date：

若由非患者本人簽署，則需說明您與患者的法律關係，並請提供相關文件，如持久授權書 **(Durable Power of Attorney, DPOA)**、死亡證明、監護權證明的副本 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：

與患者的關係 ： Relationship to Patient:	日期 Date：

根據州法規，可能需要獲得在患者住院期間為其診治的醫生的授權。

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: _____