P.O. Box 3306, Daly City, CA 94015
Email: eroi@gems-lv.org

GEMS MRN:

NAME:

DATE OF BIRTH:

EMAIL:

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
健康資料使用授權書

Completion of this document authorizes the use or disclosure of health information about you. **Please fill in completely.**
填寫這份文件即授權使用或透露有關您的健康資料。**請完整填寫。**

I AUTHORIZE **本人授權**			TO DISCLOSE TO **把資料提供給**		
Name of Disclosing Party 透露方名稱/姓名			Name of Recipient 接收者名稱/姓名		
Address/Email Address/Fax Number 地址/電郵地址/傳真號碼			Address/Email Address/Fax Number 地址/電郵地址/傳真號碼		
City 市	State 州	Zip Code 郵政編碼	City 市	State 州	Zip Code 郵政編碼

REQUESTED FORMAT: (Please select one) **索取資料的方式: (請選擇一個):**

☐ Email (encrypted) 電郵（加密）　☐ Email (unencrypted)** 電郵（未加密）**　☐ Patient Portal 病人平台　☐ Fax 傳真

☐ Sharing of PHI (to authorize exchange between the organizations/persons listed above.)
共享 PHI（授權與上述機構/個人共享資料。）

☐ Paper: 紙張　☐ Pick-up <u>OR</u> 自取 **或**　☐ Mail ($0.25/page fees may apply) 郵寄（可能需支付每頁$0.25 的用費）

Note: Sending information over unencrypted email is not secure and increases risks that your information could be intercepted, viewed, copied, or shared by an unauthorized third party. By selecting the "Email (unencrypted)" option, I acknowledge that GEMS has warned me of the risks, and I still prefer and give permission to GEMS to send the requested records through unencrypted e-mail.
**注意：使用未加密的電子郵件發送的信息並不安全，並且可能增加您的信息被未經授權的第三方截獲、讀取、複製、或分享的風險。通過選擇“電子郵件（未加密）”選項，本人承認在行健醫療中心已警示我相關風險的前提下，我仍然選擇同意授權予行健醫療中心使用未經加密的電子傳送我的醫療紀錄。

SPECIFY THE HEALTH INFORMATION FOR DATES OF SERVICE **指定健康資料的服務日期:**

From 由: ______/______/______　To 至: ______/______/______

By checking the box(es) below, I specifically authorize release of the following:
通過勾選以下方框，本人授權透露:

☐ **Complete Medical Information 全部醫療資料**　☐ Office Visit Notes 會診備註　☐ Lab/Pathology Reports 化驗測試/病理報告

☐ Immunizations 免疫接種　☐ Radiology Reports (CT, MRI, X-Rays, etc.) 放射科報告（CT 断层掃描，核磁共振， X 光片之類）

☐ Other 其它: ______________________________

GO EAST MEDICAL SERVICES
行 健 醫 療 中 心

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PROTECTED CLASSES OF INFORMATION **受保護的資料類型：**

By checking the box(es) below, I specifically authorize release of the following:
通過勾選以下方框，本人授權透露:

☐ Drug and Alcohol Abuse Diagnosis or Treatment Records
藥物及酒精濫用診斷或治療紀錄

☐ Mental/Behavioral Health Diagnosis or Treatment Records
心理/行為健康診斷或治療紀錄

☐ HIV Test Results
愛滋病毒檢測結果

☐ Genetic Testing Results
基因測試資料

☐ Psychotherapy Notes
心理治療資料

The release of the above-specified information is for the purpose of
透露以上指定資料的主要目的為：

☐ Patient/Legal Representative Request
病人／合法代表人的要求

☐ Disability Eligibility
殘障資格

☐ Continuity of Care
醫療照護連續性

☐ Continuing Medical Care by GEMS Provider:
繼續由行健醫師提供醫療護理: ______________________________

☐ Other
其它: ______________________________

DURATION: This authorization will be effective on the date of my signature and will remain in effect for one (1) year from the date of signature unless a different date is specified here ____________________(Date).
有效期：此授權在簽署後立即生效，並且除非本人在此指定有效期限______________（日期），否則在簽名日期後一 (1) 年內仍保持有效。

REVOCATION: I understand that I may revoke this authorization at any time by writing to GEMS HIS Department P.O. Box 3306 Daly City, CA 94015. My revocation will be effective upon receipt but will not apply to any information that was disclosed based on this authorization before the revocation is received.
撤銷：本人明白我有權隨時通過書面方式向行健醫療記錄部（地址為 P.O. Box 3306 Daly City, CA 94015）。提出撤銷授權申請。撤銷要求於接獲通知時即時生效，收到撤銷通知前行健醫療中心根據該授權使用/透露資料的行為則不屬此範圍。

REDISCLOSURE: I understand that once my health information is disclosed, it may no longer be protected by the federal regulations governing the privacy and security of health information.
重新透露：本人明白，一旦我的健康資料被透露，它將不再受有關健康信息隱私和安全的聯邦法規的保護。 加州法律禁止接收者進一步透露您的健康資料，除非接收者獲得您的另一次授權或法律允許透露。 此保護不適用於加州以外的接收者。

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MY RIGHTS: I understand that I may refuse to sign this authorization and GEMS may not condition my treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization, except where disclosure is necessary for treatment or eligibility for health care benefits. I understand that I may request a copy of this authorization.
本人的權利：本人明白我有權拒絕簽署此授權書。行健醫療中心不會以我簽署此授權書的決定作為我治療、付款、加入健康計劃或獲得醫療保健福利資格的條件，除非在特定情況下必須透露資料以獲得治療或醫療保健福利資格。本人明白我有權索取此授權書的影印副本。

Signature of Patient or Legal Representative* 病人或合法代表簽名	Date 日期
Name of Legal Representative 合法代表姓名	Relationship of Legal Representative 合法代表與病人的關係
Signature of Witness (Required if patient is unable to sign) 見證人簽名（病人無法自行簽字時此項必填）	Date 日期

** If you are requesting information to be sent to yourself or to a third party under your right of access to your health information, you may choose unencrypted email. If this authorization request is from a third party, GEMS must send the information in a secure manner.

** 如果您要求將資料傳送給自己或有權訪問您健康資料的第三方，您可以選擇未加密的電子郵件。 如果該授權請求來自第三方，行健醫療中心必須以安全的方式傳送資料。

STAFF USE ONLY
☐ Emailed ☐ Faxed ☐ Mailed ☐ In-Person Staff Initial _______ Date _______