NEMS NORTH EAST MEDICAL SERVICES
NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心
1033 Clement St., San Francisco, CA 94118
Tel: (415) 391-9686 | Fax: (415) 352-5103
Medical Records Fax: (415) 933-6843
Email: eroi@nems.org

NEMS MRN :

NAME:

DATE OF BIRTH:

EMAIL:

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Completion of this document authorizes the use or disclosure of health information about you. **Please fill in completely.**

I AUTHORIZE:

Name of Disclosing Party

Address/Email Address/Fax Number

City State Zip Code

TO DISCLOSE TO:

Name of Recipient

Address/Email Address/Fax Number

City State Zip Code

REQUESTED FORMAT: (Please select one): ☐ Email (encrypted) ☐ Email (unencrypted)** ☐ Patient Portal
☐ Fax ☐ Sharing of PHI ☐ Paper (Paper copies: Per Page Fees May Apply)
☐ Other (agreed upon by patient and NEMS): _____

****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 NEMS has warned me of the risks, and I still prefer and give permission to NEMS to send the requested records through unencrypted e-mail.

SPECIFY THE HEALTH INFORMATION FOR DATES OF SERVICE From: ___/___/___ To: ___/___/___

By checking the box(es) below, I specifically authorize release of the following: ☐ **Complete Medical Information**
☐ Office Visit Notes ☐ Lab/Pathology Reports ☐ Immunizations ☐ Radiology Reports (CT, MRI, X-Rays, etc.)
☐ Hospital Reports ☐ Other: _____

PROTECTED CLASSES OF INFORMATION: By initialing below, I specifically authorize release of the following:
_____ Substance Use/Drug Abuse Information _____ Mental/Behavioral Health/Psychotherapy Notes
_____ HIV Test Results _____ Genetic Testing Results

The release of the above-specified information is for the purpose of:
☐ Patient/Legal Representative Request ☐ Disability Eligibility ☐ Other: _____
☐ Continuity of Care ☐ Continuing Medical Care by NEMS Provider: _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of signature unless a different date is specified here_____(Date).
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 other has acted in reliance upon this authorization.
REDISCLOSURE: 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.

I may refuse to sign this authorization, without affecting my receiving services and/or treatment.

Date

Signature of Patient or Legal Representative

State Relationship if not Patient

Witness (Required if Patient unable to sign)

Patient has a right to a copy of this authorization

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

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東北會員黃卡號碼：

姓名:

出生日期:

電郵地址:

健康資料使用授權書

填寫這份文件即授權使用有關您的健康資料。**請完整填寫。**

我授權:

透露方名稱/姓名

地址/電郵地址/傳真號碼

市 州 郵政編號

把資料提供給:

接收者名稱/姓名

地址/電郵地址/傳真號碼

市 州 郵政編號

索取資料的方式: (請選擇一個): ☐ 電郵（加密） ☐ 電郵（未加密）** ☐ 病人平台 ☐ 傳真
☐ 分享受保护健康信息 ☐ 索取印刷版本（印刷副本：可能收取每頁打印費用）
☐ 其它（會員及東北醫療中心雙方同意的方式）:

**注意：使用未加密的電子郵件發送的信息並不安全，並且可能增加我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，我承認在東北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東北醫療中心使用未經加密的電子傳送我的醫療紀錄。

指定健康資料的服務日期: 由: / / 至: / /

通過勾選以下方格，我授權透露: ☐ **全部醫療資料** ☐ 會診備註 ☐ 化驗測試/病理報告 ☐ 免疫接種
☐ 放射科報告（CT 断层掃描，核磁共振， X 光片之類） ☐ 醫院報告
☐ 其它:

請簽上姓名縮寫以透露以下保密資料:

_____ 濫用藥物資料
_____ 愛滋病資料
_____ 心理/行為健康資料/心理治療資料
_____ 基因測試資料

透露以上指定資料的主要目的：

☐ 病人／法律代表人的要求 ☐ 殘障資格 ☐ 其它:
☐ 醫療照護連續性 ☐ 繼續由東北醫師提供醫療照顧:

有效期：此授權在簽署後立即生效，並且除非本人在此指定另外日期 _____（日期），否則在簽名日期後一年內仍保持有效。

撤銷：本人有權隨時以書面通知撤銷此授權。撤銷於接獲書面通知時即生效，但撤銷前透露資料的一方根據該授權作出的透露資料行為則不屬此範圍。

重新透露：本人明白，除非獲得本人重新授權，或除非法律上特別要求或許可，否則接收資料的一方進一步使用或透露本人健康資料則屬違法。

本人有權拒絕簽署此授權書。拒絕簽署並不會影響本人接受治療的權益。

日期 病人／法律代表簽名 若簽名者非病人本人，請說明與病人的關係

見證人（若病人無法簽名，必須由見證人簽名）

病人有權獲取此授權書副本

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