NEMS NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心
1033 Clement Street, 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

City State ZIP

TO DISCLOSE TO:

Name of Recipient

Address/Email Address/Fax

City State ZIP

SPECIFY TYPE OF ACCESS REQUESTED: ☐ Fax ☐ Patient Portal ☐ Email (encrypted)

☐ Email (unencrypted)** ☐ 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 RECORDS: By checking boxes below, I specifically authorize release of the following:

☐ **COMPLETE MEDICAL INFORMATION** ☐ **MEDICAL INFORMATION -** Specify Types/Date(s):

☐ Visit Note ☐ Lab/s ☐ Immunization ☐ Other: _____ From:_____ To:_____

INITIAL below if you want to release protected classes of information:

_____Mental/Behavioral Health Notes _____ Substance Abuse Information

_____HIV Information _____ Psychotherapy Notes

The above-specified information is for the purpose of:

☐ Continuing Medical Care by NEMS Provider: _____

☐ Patient/Legal Representative Request ☐ Other: _____

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.

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

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東北醫療中心 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

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: ☐ 傳真 ☐ 病人平台 ☐ 電郵（加密）

☐ 電郵（未加密）** ☐ 其它（得到病人及東北醫療中心同意）: _____

***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，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。*

指定資料: 通過勾選以下方格，我授權透露:

☐**全部醫療資料** ☐ **某些醫療資料 – 請指明類型/日期**:

☐ 會診備註 ☐ 化驗測試 ☐ 免疫接種 ☐ 其它: _____ 由:_____ 至:_____

請簽上姓名縮寫以透露以下保密資料:

_____心理/行為健康資料 _____ 濫用藥物資料

_____愛滋病資料 _____ 心理治療資料

以上指定資料是被用作:

☐醫療照顧（東北的醫生）:

☐病人 / 法律代表的要求 ☐ 其它 _____

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

撤銷：會員/病人有權隨時以書面通知撤銷本授權。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：我明白，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

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