CEDARS-SINAI MEDICAL CENTER.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

使用或披露健康资讯授权书

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.
填写此文件即授权披露及/或使用如下所述的个人健康资讯，符合加州和联邦关于这类资讯隐私权的法律。**未能提供所要求的全部资讯可能使本授权书无效。**

USE AND DISCLOSURE OF HEALTH INFORMATION
健康资讯的使用和披露

I hereby authorize the use or disclosure of my health information as follows
我在此授权按照下列方式使用或披露我的健康资讯：

Patient Name / 病人姓名：

_____

MRN / 病历号码：_____

Date of Birth / 出生日期：_____

Persons/Organizations authorized to use or disclose the information
被授权使用该资讯的人/组织：[1]

_____

_____

Persons/Organizations authorized to receive the information (must include name, address, phone number, fax number) / 被授权获得该资讯的人/组织（必须包括名称、地址、电话号码、传真号码）：

_____

_____

This Authorization applies to the following information (select only one of the following) /
本授权书适用于下列资讯（仅在下面选择一项）：[2]

A. ❑ All health information pertaining to any medical history, mental or physical condition and treatment received. [Optional] Except:
关于任何病史、心理或身体状况以及接受的治疗的所有资讯。[可选] 但不包括：_____

❑ Only the following records or types of health information (including any dates)
只有下列健康资讯记录或类型（包括任何日期）：_____

B. I specifically authorize release of the following information (check as appropriate)
我特别授权释放下列信息（勾选适当的选项）：[2,3]

- ❑ Mental Health treatment information / 心理健康治疗资讯
- ❑ HIV test results / HIV 测试结果
- ❑ Alcohol/Drug treatment information / 酗酒 / 吸毒治疗资讯

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.
披露或使用心理治疗笔记需要单独的授权书。

PURPOSE / 目的

Purpose of requested use or disclosure/要求使用或披露的目的：[4] ❑ Patient request / 病人要求；
❑ OR Other / 或者其他：

EXPIRATION / 到期

This Authorization expires (not to exceed 24 months) / 本授权书的到期日是 (不得超过 24 个月)：[5]

_____

(Insert Date or Event / 填写日期或事件)

NOTICE OF RIGHTS AND OTHER INFORMATION
权利和其他资讯通告

- I may refuse to sign this Authorization. / 我可以拒绝签署这份授权书。
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address
  我可以在任何时候撤销这份授权书。我的撤销必须书面做成，并且由我或者代表我的人签名，并且交到下列地址：_____
  _____
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
  我的撤销将在收到时生效，但是对于请求者或者其他人已经信赖本授权书行事的情形没有效力。
- I have a right to receive a copy of this authorization. / 我有权利收到一份本授权书。[6]
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. / 治疗、支付、加入或者福利资格均不会以我提供或者拒绝提供这份授权书为条件。[7]
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. / 根据该授权书披露的资讯，接受者可以重新披露，并且不再受联邦保密法律（HIPAA）保护。然而，加州法律禁止接受健康资讯的人进一步进行披露，除非获得了我对这种披露的另一项授权书，或者除非法律明确要求披露。
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose. If this box ❑ is checked, the Requestor will receive compensation for the use or disclosure of my information. / 我可以检查或获取一份我被要求使用或披露的健康资讯。如果勾选了此框 ❑，则请求者因使用或披露我的资讯将获得补偿。

SIGNATURE / 签名

Date / 日期：_____ Time / 时间：_____ a.m./上午 / p.m./下午

Signature / 签名：_____
(Patient / Representative / Spouse / Financially Responsible Party)
(病人 / 代表 / 配偶 / 经济责任方)

If signed by someone other than the patient, state your legal relationship to the patient
如果签名人不是病人，请说明你与病人的关系：[8] _____
_____
_____

Witness / 证人：_____

Hospital Representative Processing Request/ 处理请求的医院代表：
_____ Date/ 日期：_____
(Signature/ 签名)

[1] If the Authorization is being requested by the entity holding the information, this entity is the Requestor. 如果该授权书是由持有该资讯的实体请求的，则该实体为请求者。

[2] This form may not be used to release both psychotherapy notes and other types of health information (see 45 CFR"164.508 (b)(3)(ii). If this form is being used to authorize the release of psychiatric health information, a separate form must be used to authorize release of any other health information. An authorization for use or disclosure of HIV test results must specifically state that it authorizes the use or disclosure of HIV test results and must be signed by a witness.

本表格不得用于同时释放心理治疗笔记和其他类型的健康资讯（参阅《联邦法典》第 45 卷第 164.508 (b)(3)(ii)款）。如果本表格用于授权释放心理健康资讯，则必须使用一份独立的表格来收取释放任何其他健康资讯。使用或披露 HIV 测试结果的授权书必须明确说明它授权使用或披露 HIV 测试结果，并且必须由一名证人签名。

3 If mental health information covered by Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons there- fore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party. / 如果病人要求把 Lanterman-Petris-Short 法案包括的心理健康资讯释放给第三方，那么负责该病人的医生、持照心理学家、拥有社工硕士学位的社工或婚姻及家庭治疗师必须批准该释放。如果该释放没有获得批准，则应该记录没有批准的理由。病人最有可能自己合法获取一份记录，然后把记录提供给第三方。

4 The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose. / 如果个人草签本授权书而没有提供或者选择不提供目的声明，那么“根据个人要求”便是目的的充分声明。

5 If authorization is for the use or disclosure of protected health information for research, including the creation and maintenance of a research database or repository, the statement "end of research study", "None", or similar language is sufficient. / 如果授权是为了研究而使用或者披露受保护的健康资讯，包括创建和维护研究数据库或存储库，那么“研究学习结束”、“无”或类似语言的声明就足够了。

6 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR"164.508 (d)(1), (e) (2)). / 根据 HIPAA，当涵盖的实体请求一份授权书以便自己使用或披露时，必须向该个人提供一份授权书（参阅《联邦法典》第 45 卷第 164.508 (d)(1), (e) (2)款）。

7 If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
如果 HIPAA 承认的对这项声明的任何例外适用，并且当涵盖的实体可以把无法取得这类授权作为治疗、加入保健计划或福利资格的条件时，那么这项声明必须进行变更，以便描述拒绝签署该授权书对该个人的后果。涵盖的实体在下列方面准许把治疗、加入保健计划或福利资格以提供授权书为条件： (i) 进行研究相关的治疗，(ii) 获取关于该个人的保健计划资格或加入决定相关的资讯或者确定承保或风险评级的资讯。但是，在任何情况下不得要求个人授权披露心理治疗笔记。

8 The requestor is to complete this section of the form. / 本表格的此节由请求者填写。

Reference: Welfare and Institutions Code Section 5328.7 / **参考：**《福利与机构法》第 5328.7 款