Authorization to Disclose or Request Protected Health Information

(HIPAA Compliant Authorization Form)

(Chinese/中文)

披露或請求受保護健康資訊授權書

（遵照「健康保險轉移與責任法」（HIPAA）授權表）

I, ______________________ ______________________ ______________________
Name of Patient (Please Print) *Patient's Date of Birth (mm/dd/yy)* *Patient's Phone Number*

of ____
Patient's Address

hereby authorize the following Service Provider:
County Agency/Program/Office: ______________________
Address: ______________________

本人，______________________ ______________________ ______________________
病人姓名（請用大寫字母填寫） *病人出生日期（月/日/年）* *病人電話號碼*

____
病人住址

在此授權以下服務提供者：
郡機構/計劃/辦事處：______________________
地址：______________________

1. To ☐ **disclose** individually identifiable health information to and/or ☐ **receive** information on my behalf from:

   ______________________ or his/her designee ______________________
   Supervisor/County Official *Name*

1. ☐ 代表我向以下人士**披露**可識別個人身份的健康資訊及/或 ☐ 從以下人士處**接收**資訊：

   ______________________ 或其指定代表 ______________________
   主管/郡政府官員 *姓名*

2. The following specific information is authorized: ______________________
   ____

2. 授權披露或接收以下具體資訊：______________________
   ____

3. This authorization is in effect for the period of time from ______________ to ______________
   (Date or Event) *(Date or Event)*

3. 本授權書有效期從 ______________ 至 ______________
   （日期或事件） *（日期或事件）*

4. This authorization allows the indicated service provider to share the specified information for:
   ☐ A single use or disclosure available at the time of authorization
   ☐ On-going use or disclosure for the time period identified in Item 3

4. 本授權書允許指定的服務提供者因以下目的分享指定的資訊：
   ☐ 在授權時一次性使用或披露資訊
   ☐ 在第 3 項規定的階段內持續使用或披露資訊

5. The information will be used/disclosed for the following purpose(s): ____
____

5. 因以下目的使用/披露資訊：____
____

6. The source records for information disclosure:
☐ **ARE** protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) because the records contain information on prior, current, or planned substance abuse treatment. If these records are protected by regulation 42 CFR Part 2, I understand the recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted within the regulation. 42 CFR Part 2 also restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.
☐ **ARE NOT** protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand the Federal Privacy Rule (45 CFR Part 160 and 164, HIPAA) requires I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal HIPAA regulations.

6. 資訊披露的來源記錄：
☐ **受**聯邦「酗酒與吸毒病人記錄保密」法規（「聯邦法規集」第 42 篇第二部份）保護部份，因爲記錄包括以前、目前或計劃進行的藥物濫用治療資訊。如果此類記錄受「聯邦法規集」第 42 篇第二部份法規的保護，我理解除非獲得我的書面授權明確許可，接受資訊一方不得進一步披露該資訊，但法規許可的情況除外。「聯邦法規集」第 42 篇第二部份還禁止以任何方式使用該資訊對任何酗酒或吸毒病人進行刑事犯罪調查或起訴。
☐ **不受**聯邦「酗酒與吸毒病人記錄保密」法規（「聯邦法規集」第 42 篇第二部份）保護部份。如果此類記錄不受「聯邦法規集」第 42 篇第二部份保護，我理解「聯邦隱私權法規」（「聯邦法規集」第 45 篇第 160 和 164 部份，「健康保險轉移與責任法」）要求通知我根據本授權書使用或披露的資訊可能會被重新披露，並不再受聯邦「健康保險轉移與責任法」法規的保護。

7. I understand that:
   - Service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure identified in Item 5.
   - Fairfax County will not condition the provision of services related to treatment, payment, enrollment, or eligibility for benefits on my decision to sign this authorization.
   - I may revoke (or cancel) this authorization at any time by submitting a written statement of revocation to the service provider whose address is provided above, except to the extent that the identified service provider already has taken action based on this authorization.
   - I have a right to request and receive a Notice of Privacy Practices from Fairfax County.
   - The information to be released has been fully explained to me and this authorization is given of my own free will.

7. 我理解：
   - 根據本授權書使用或披露資訊的服務提供者必須在完成第 5 項指定的披露目的時儘量分享最少的必要指定資訊。
   - Fairfax 郡不會根據我是否決定簽署本授權書對與治療、付款、註冊或享受福利資格相關之服務附加任何條件。
   - 我可以隨時向以上地址的服務提供者發出書面撤銷授權聲明，撤銷（取消）本授權書，除非該服務提供者已根據本授權書採取行動。
   - 我有權要求 Fairfax 郡給我寄送一份「隱私權管理方法通知」。
   - 關於披露資訊，我已經獲得充份解釋，我自願同意給予本授權。

8. Please send or communicate the authorized information to the following address, phone number or fax number:
____

8. 請將經授權披露的資訊發送或傳送至以下地址、電話號碼或傳真號碼：
____

Resident of Fairfax County Signature: ________________________________ Date: ____________________

Relationship to patient: ☐ *Self* ☐ *Parent of Minor Child* ☐ *Guardian* ☐ *Legally Authorized Representative*

Fairfax 郡居民簽字：________________________________ 日期：____________________

與病人的關係： ☐ *本人* ☐ *未成年子女的父親/母親* ☐ *監護人* ☐ *法律授權代表*