2003年1月26日

病人同意書

爲遵守紐約州立之1996年健康保險流通和責任法案的新規定，本醫務所公佈了此法案給與您的某些權利，以及我們對醫療資料所做之保密和維護的守則。本醫務所之醫療資料保密通知書裏，其中有一段說明了您身爲病人在法律下所應有的權利。在您簽署此病人同意書前，您有權閱讀本醫務所的醫療資料保密通知書。此醫療資料保密通知書的內容，也許日後因需要會有所更改，屆時您可以與本醫務所聯絡要求索取一份紙版複印。

在醫療程序、領取醫療費和執行健康照顧方面，您有權限制本醫務所，如何運用或透露您的醫療資料。您有權以親自簽署的書信來取消此同意書。但是，這並不影響本醫務所，在收到您正式書面取消信之前，根據醫療程序之需要和您原先的同意的情況下，對您的健康資料所做的運用和透露。

病人清楚的瞭解以下幾個重點：

- 病人的保密醫療資料將因爲醫療程序需要、領取醫療費或執行健康照顧而被運用或透露；
- 本醫務所有一份醫療資料保密通知書，提供機會給病人參閱；
- 本醫務所有權更改此醫療資料保密通知書；
- 病人有權限制本醫務所如何運用或透露病人的醫療資料，但本醫務所並不需要贊同病人所提出的限制；
- 病人有權在任何期間，以親自簽署的書信來取消此同意書，接到取消信後，本醫務所將停止運用或透露病人的醫療資料；
- 本醫務所可以要求病人簽此同意書後才開始爲病人進行醫療的程序。

同意書簽署人 _____
病人或病人代表姓名的正楷

⇨ _____ _____
簽　署　　日期

與病人的關係 _____
〔若是病人代表〕

見證人 _____
醫務所代表人的姓名正楷

⇨ _____ _____
簽　署　　日期

中文翻譯版-請以英文原稿爲準

2003年1月26日

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name – Patient or Representative

_____ ___/___/___

Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____

Printed Name – Practice Representative

_____ ___/___/___

Signature Date

同意保密紙版