TRIBECA RADIATION

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS
授权获得/公开医疗记录

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)
（应健康保险隐私和责任法案，45 C.F.R 160 和 164 部分要求）

I authorize _____x_____any and all medical entities_____ (healthcare provider)_____ to release my medical records to the following individual or entity:
我授权任何 _____ 和所有医疗单位 _____(保健服务提供者)_____来向下列个人或单位公开我的医疗记录：

Individual or Entity 个人或单位: _____

Patient Name 患者姓名: _____ Date of Birth 出生日期: _____/_____/_____

Address 住址: _____

City 城市: _____ State 州: _____ Zip 邮编_____

This authorization for release of information covers the period of healthcare:
本信息公开授权涵盖医疗服务的整个时期：

From: _____ To _____ ***OR*** all past, present, and future periods.
从：_____ 到 _____ 或 所有过去、现在和未来的医疗时期。

☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
我授权公开我的完整医疗记录（包括与心理保健、传染病、艾滋病病毒感染或艾滋病有关的记录和酒精或药物滥用治疗记录）。

OR 或

☐ I authorize the release of my complete health record with the exception of the following information:
我授权公开的完整健康记录不包括如下信息：

- ☐ Mental health records 心理健康记录
- ☐ Communicable diseases (including HIV and AIDS) 传染病（包括艾滋病病毒感染和艾滋病）
- ☐ Alcohol/drug abuse treatment 酒精/药物滥用治疗
- ☐ Other (please specify): _____ 其他（请注明）：_____

The purpose of this release 信息公开的目的: _____

This medical information may used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
我授权接受此类医疗信息的人可将其用于医疗或咨询、开账单或索赔付款或我列出的其他目的。

This authorization shall be in force and effective for one year (365 days) from the date of my signature below.
本授权自我下方签字之日起 365 天内有效。

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I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.
我明白，我有权随时以书面形式撤销此授权。我明白，如果任何个人或单位已经根据我授权实施的部分，或者如果获得授权是纳入保险范围的条件，承保人据此才有同意索赔的合法权利，那撤销对实施部分无效。

I understand that my treatment, payment, enrollment, or eligibility for benefits will not conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
我明白，我治疗、支付、注册或领取保险金的资格并不取决于我是否在本授权签字。我明白，根据本授权所用或已公开信息可能会被接受者再次公开，可能不会再受到联邦或州法律的保护。

_____ _____

Signature of patient or personal representative Date 日期
患者或授权代表签名

_____ _____

Printed name of patient or personal representative Relationship to the patient
患者或授权代表印刷体姓名 与患者关系