|  |
| --- |
| **Medical Record No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ID / Passport No#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Birth date:**  \_\_\_ /\_\_\_ /\_\_\_\_\_ (MM/DD/YYYY)  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Telephone No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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**Authorization for**

**Disclosure of Medical Information**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, AUTHORIZE TAIWAN ADVENTIST HOSPITAL TO RELEASE TO:**

(Please Print)

**Appropriate Taiwan Adventist Hospital Medical Specialist**

(Name of hospital, company or person to whom the information will be released) (Contact Number: □Telephone □Fax )

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Address or E-mail of receiving party)

* **How would you like this information sent to the receiving party? □ Fax □ E-mail □ Registered Mail**

**THE FOLLOWING INFORMATION FROM MY MEDICAL RECORT:**

□ Laboratory Report □ Urine Test Report □ Pathology Report □ X-Ray Report

□ MRI Report □ C-T Report □ Sonography Report □ Bone Scan

□ EKG Report □ EMG Report □ Endoscopy Report □ O.P.D Report

□ Discharge Summary □ Pulmonary Function Test Report **☑** All Medical Record

□ other (specify): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR THE PURPOSE OF:**

□ continuation of medical treatment □ payment of bill 　 □ education

□ worker’s compensation □ legal purpose 　　□ insurance purposes

□ telemedicine 　 　□ second opinion

□ at the request of patient or the patient’s legal representative for personal access

□ other (specify): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THE INFORMATION TO BE RELEASED WILL COVER THE TIME PERIODS FROM**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(MM/DD/YYYY)(“Present” equals date of signature)

|  |
| --- |
| This authorization shall be in force and effect until \_\_\_\_\_/\_\_ \_\_\_/ \_\_\_\_\_\_ at which time this authorization to use or disclose this protected medical information expires.  I understanding that as set forth in Taiwan Adventist Hospital notice of Medical Information practices, that I may revoke this authorization at any time by giving written notice to the Medical Room of the Adventist Hospital except to the extent that Taiwan Adventist has already acted in reliance on this contract. This authorization will automatically expire when the information requested has been disclosed, if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed. I understand that information disclosure pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by local law. |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_

Signature of Patient Date

If the patient is a minor, not mentally competent or has given power of attorney to an individual, please have an

authorized person sign below in lieu of the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_

Authorized Representative Date

□ Parent □ Legal Guardian □ Power of Attorney\* □ Other\*\*

\* If signing as power of attorney, please attach a copy of the power of attorney.

\*\* If signing as “other” attach detailed explanation and supporting documentation.

**- PATIENT ACCESS FEE MAY APPLY -**