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| *北卡罗来纳州婴幼儿计划* | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| *健康信息披露授权* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 儿童姓名： | | | |  | | | | | | | | | | | | | | 出生日期： | | | | | | |  | | | |
| 儿童医疗记录编号： | | | | |  | | | | | | | | | | | | |  | | | | | | |  | | | |
| 本人， |  | | | | | | | | | | | | 特此授权 | | | | | | | |  | | | | | | | |
| *（父母/法定监护人或个人代表）* | | | | | | | | | | | | | | | | | *（提供者/机构/个人的名称/姓名）* | | | | | | | | | | | |
| 向以下方披露或与以下方交流上述儿童的记录（口头、书面和/或电子）中所含的特定健康信息 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  |  | | | | | | | | | | | | |  | |  | | |  |  |
| *儿童姓名* | | | | | | | |  | *地址* | | | | | | | | | | | | |  | | *电话* | | |  | *传真（可选）* |
|  | | | | | | | |  |  | | | | | | | | | | | | |  | |  | | |  |  |
| *儿童姓名* | | | | | | | |  | *地址* | | | | | | | | | | | | |  | | *电话* | | |  | *传真（可选）* |
|  | | | | | | | |  |  | | | | | | | | | | | | |  | |  | | |  |  |
| *儿童姓名* | | | | | | | |  | *地址* | | | | | | | | | | | | |  | | *电话* | | |  | *传真（可选）* |
| 以便： | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 待披露/交流的具体信息（请勾选所有适用的选项）： | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 出生记录/历史信息 | | | | | | 物理治疗评估 | | | | | | 多学科评估 | | | | | | | | | | | | | | | | |
| 健康和医疗记录 | | | | | | 职业治疗评估 | | | | | | 个别化家庭服务计划 [IFSP] | | | | | | | | | | | | | | | | |
| 实验室结果 | | | | | | 言语和语言评估 | | | | | | 资格状况 | | | | | | | | | | | | | | | | |
| 入院/出院总结 | | | | | | 发展评估 | | | | | | 进度报告/进度说明 | | | | | | | | | | | | | | | | |
| 眼科评估 | | | | | | 营养评估 | | | | | | 其他[具体说明] | | | | | | | | | | |  | | | | | |
| 听力评估 | | | | | | 教育评估 | | | | | | 其他[具体说明] | | | | | | | | | | |  | | | | | |
| 社会历史 | | | | | | 心理评估 | | | | | | 其他[具体说明] | | | | | | | | | | |  | | | | | |
| 发展进程 | | | | | | 医学评估 | | | | | | 限制 见具体要求 | | | | | | | | | | | | | | | | |
| 本人了解，此授权将于以下日期，或发生以下事件或条件时到期： | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **（不超过一年）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 本人了解，如果本人未能指定到期日或条件，本授权应在实现其目的所需的时间（最长一年）内有效，但为金融交易进行的披露除外，相关授权无限期有效。本人亦了解，本人可以在任何时候通过签署本表格底部的*撤销部分*来撤销此授权。本人还了解，在撤销日期之前对此次授权采取的任何行动均是合法且具有约束力的。  本人了解，本人信息的索取人可能无法保证信息不被再次披露；但是，如果该信息受《联邦药物滥用保密条例》的保护，除非州或联邦法律另有规定，否则未经本人进一步书面授权，接收方不得再次披露该信息。  本人了解，如果本人的记录包含与 HIV 感染、艾滋病或与艾滋病相关疾病、酗酒、吸毒、心理或精神疾病或基因检测相关的信息，本次披露可能会包含这些信息。本人了解，本人可以申请限制此类信息的披露。本人亦了解，本人可以拒绝签署该授权书。本人还了解，如果本人拒绝签署本授权书，该婴幼儿计划不能拒绝提供治疗或福利资格。（但是，请注意，如果治疗与研究相关，一旦未获得授权，治疗可能会被拒绝。）  本人还了解，本人将收到一份已签署的授权书。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | |  | | | | |  | | |  | | | | | | |
| *父母、客户、法定监护人、个人代表签名* | | | | | | | | | | |  | | | *日期* | | | | |  | | | *关系/授权* | | | | | | |
|  | | | | | | | | | | |  | | |  | | | | |  | | |  | | | | | | |
| *联署人签名* | | | | | | | | | | |  | | | *日期* | | | | |  | | | *关系/授权* | | | | | | |
| |  | | --- | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **健康信息披露授权——撤销部分** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 本人特此申请撤销 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | *儿童姓名* | | | | | | | | | | | | |
| 签字人： | | |  | | | | | | | | | | | | | | | | 日期 | | | |  | | | | | |
|  | | | *授权书签字人姓名* | | | | | | | | | | | | | | | |  | | | *签字日期* | | | | | | |
| 的健康信息交流/披露授权，生效日期为 | | | | | | |  | | | *（日期）* | | | | | | | | | | | | | | | | | | |
| 本人了解，在撤销日期之前对此次授权采取的任何行动均是合法且具有约束力的。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| *父母、客户、法定监护人、个人代表签名* | | | | | | | | | | | |  | | | *日期* | | | | |  | | *关系/授权* | | | | | | |
|  | | | | | | | | | | | |  | | |  | | | | |  | |  | | | | | | |
| *联署人签名* | | | | | | | | | | | |  | | | *日期* | | | | |  | | *关系/授权* | | | | | | |