Commonwealth Healthcare Corporation

Commonwealth of the Northern Mariana Islands
1 Lower Navy Hill Road, Navy Hill, Saipan, MP 96950

Health Information Management Department

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

[Individual/Patient/Client/Insured]:

영문이름(성/이름)	생년월일(월/일/연도)	
Name of Individual/Previous Names	*Birth Date*	*Medical Record Number*
현 거주지 주소(한국주소와 역순으로 뒤에서 부터 표기)	거주도시이름	연락가능한전화번호 ((+82)10-****-****)
Street Address / P.O. Box Number	*City, State, Zip*	*Phone*

AUTHORIZES:	***DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:***
MVA	
Individual(s)/agency/organization making disclosure	*Individual(s)/agency/organization receiving information*
Street Address / P.O. Box Number	*Street Address / P.O. Box Number*
City, State, Zip Code	*City, State, Zip Code*

INFORMATION TO BE USED and/or DISCLOSED:
The following is a specific description of the health information I authorize to be used and/or disclosed PCR TEST

[Check all that apply]

□ Emergency Room Record	□ Discharge Summary	□History and Physical	□Radiology Report
□ Laboratory Reports	□ Pathology Report	□Operation Report	□Progress Notes

In compliance with the Health Insurance Portability and Accountability Act of 1996, which require special permission to release otherwise privileged information, please release records pertaining to: **[Check all that apply]**

□Mental Health	□Developmental Disabilities	□Alcohol and/or Drug Abuse
□HIV test results	□Other (Specify):_____	

For the Following Treatment Date(s): From_____/_____/_____ **To**_____/_____/_____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

□ Further Medical Care	□ Coordinating Care for Dependent/Spouse	□Insurance Eligibility/Benefits
□Claims Resolution	□Other (Specify): _____	

EXPIRATION DATE: This authorization is good until (indicate date or event) _____ or six (6) months from the day of signature if no date or event is specified. By signing this authorization, I am confirming that it accurately reflects my wishes.

I release the Commonwealth Healthcare Corporation from all legal liability that may arise as a result of the release of the above information.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: 서명 **DATE:** 작성일자(월/일/연도)

Relationship to patient: □ Self □Parent □Guardian □Conservator □Executor of Estate □Power of Attorney □Other: _____

P.O. Box 500409 CK, Saipan, MP 96950
Telephone: (670) 236-8356 FAX: (670) 236-8357 / 234-8930
Email: administration@chcc.gov.mp

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Receive Copy of This Authorization -** I understand that if I sign this authorization, I will be provided with a copy of this authorization.

- **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that Commonwealth Healthcare Corporation (CHCC) may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding:
  a) research-related treatment,
  b) health plan enrollment or eligibility,
  c) the provision of health care that is solely for the purpose of creating protected health information (PHI) for disclosure to a third party.

- **Right to Withdraw This Authorization -** I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to CHCC's Health Information Management Department. I am aware that my withdrawal will not be effective until received by CHCC and will not be effective regarding the uses and/or disclosures of my health information that CHCC has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

- **Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Management Department.

HIV Related Information: In the event that information release constitutes confidential HIV related information protected under federal and local laws: *This Information has been disclosed to you from records whose confidentiality is protected by federal and local law. Federal law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose*.

Psychiatric Information: In the event that information released constitutes confidential psychiatric information protected under federal laws: *This information has been disclosed to you from records whose confidentiality is protected by federal laws. Federal law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.*

Drug and Alcohol Abuse Records: In the event that information released is protected by the Health and Human Services Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: *This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient*.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

CONSENT OF MINOR: A minor patient's signature is required on the patient signature line to release the following information ONLY: *Conditions relating to birth control, STD's including HIV/AIDS, pregnancy-related services and substance abuse diagnosis or treatment.* If a minor patient is deemed an emancipated minor and is authorized to consent to health care without parental consent under federal or CNMI law, an authorization for release of information from the minor is required.*45 CFR 164.502(g)(3).* A parent or legal guardian signature is required for the release of all other health care information for unemancipated minors.

For Office Use Only:

DATE of Release:_____

PRINT / SIGNATURE OF HIMD Staff: _____

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