HEALTH SERVICES

TRIHEALTH PHYSICIAN OFFICE AUTHORIZATION FOR TREATMENT OF CHILD
TRIHEALTH 医师事务所儿童诊疗授权书

Name of Child (儿童姓名): ____

Child’s Birth Date (儿童的出生日期): ____________________________________

Name of Consenting Parent/Legal Guardian (同意此授权书的父母/ 法定监护人的姓名):

____

Parent or legal guardian consent must be provided for treatment of a child (minor patient under the age of 18). We understand there are times that it may not be possible for you to accompany your child to each visit and it may be more convenient to have prior authorization for delivery of medical treatment directly to a child without the parent or legal guardian being present. Therefore, the providers in this office will accept the below authorization to treat your child for any visit. If you wish to authorize treatment to your child when another adult brings your child in, this authorization must specify the name(s) of the adult(s) over the age of 18 who is authorized to bring your child in for treatment.

若要对儿童（年龄未满18周岁的未成年患者）进行治疗，必须出具父母或法定监护人的同意书。我们理解，您可能无法每次都陪同您的孩子前来就诊，若能事先获得授权，使得在没有父母或法定监护人在场的情况下，我们能够对您的孩子直接实施诊疗，这样可能更为方便。因此，本事务所的医务人员将会接受以下授权来对您的孩子进行诊疗。如果您想要授权其他成年人带领您的孩子前来诊疗，必须在本授权书中注明年满18周岁的成年人的姓名，相关成年人将获得授权，能够带领您的孩子接受诊疗。

Special Note about Preventive Care Visits and Immunizations

Preventive visits are an opportunity to provide education on your child's growth and development as well as directly address all of your concerns. Important details about your child may not be available from caregivers, adult siblings or grandparents. Also during these preventive care visits, important vaccinations are administered. It is vitally important that you understand the risks and benefit of each vaccine by reviewing a vaccine information sheet for each vaccine given. **We would PREFER that the parent or legal guardian be present for preventive care visits.** However, if this is not possible, this authorization for treatment may be used as well, for preventive care visits and administration of vaccinations.

关于预防性护理就诊和免疫的特别说明

借助预防性就诊，我们可以为您孩子的成长和发育提供一些指导意见，还能直接解除您的所有顾虑。关于您孩子的那些重要而详细的信息，您可能无法从陪护人员、家人或孩子的祖父母那获得。另外，在预防性护理就诊期间，我们会为您的孩子接种重要的疫苗。对于每次要注射的疫苗，您需要仔细阅读疫苗信息卡来了解每个疫苗的风险和好处，这一点至关重要。**在预防性护理就诊时，我们希望父母或法定监护人能够在场。**但若无法到场，也可在预防性护理就诊和疫苗接种时使用本诊疗授权书。

AUTHORIZATION TO ALLOW OR NOT ALLOW PROVIDERS TO TREAT CHILD WHEN NOT ACCOMPANIED BY ANY ADULT

(You Must check 1 of the boxes below)

允许或不允许医务人员对没有成年人陪同的儿童进行诊疗的授权书

（您必须勾选下方的一个方框）

☐ By checking this box, I DO authorize treatment of my child when my child is not accompanied to the office by me or any of the adult(s) listed below. The providers may give any such treatment the providers determine is appropriate for my child, including but not limited to preventive care visit, physical exam, re-check, sick visit, diagnostic examination, immunizations and injections, X-rays, lab tests, and any prescription of any medication deemed necessary at that time.

若勾选此框，即表示我授权当我的孩子没有我或下方所列成年人陪同的情况下，能够在事务所接受诊疗。医务人员可以对我的孩子实施认定为合适的任何诊疗方案，包括但不限于预防性护理诊疗、体格检查、重复检查、患病诊疗、诊断检查、疫苗和注射、X光、医疗试验，以及当时视为必要的任何药物处方。

☐ By checking this box, I DO NOT authorize treatment of my child unless accompanied to the office by me or any of the adult(s) listed below.

若勾选此框，即表示我不授权当我的孩子没有我或下方所列成年人陪同的情况下接受治疗。

(Complete and sign page 3) **（填写并签署第 3 页的内容）**

AUTHORIZATION TO ALLOW PROVIDERS TO TREAT CHILD
WHEN ACCOMPANIED BY BELOW LISTED ADULT(S)

(Complete this section only if you want another adult to be able to bring your child in for treatment)

授权医务人员在儿童没有下方所列
成年人的陪同时对其进行诊疗

（仅当您希望其他成年人能够携同您的孩子前来接受诊疗时，才填写此部分）

I give the office authorization to treat my child for any such treatment the providers determine is appropriate for my child, including but not limited to preventive care visit, physical exam, re-check, sick visit, diagnostic examination, immunizations and injections, X-rays, lab tests, and any prescription of any medication deemed necessary when brought to the office by the following adult(s):

我授权，当我的孩子由以下成年人陪同前来事务所寻求诊疗时，医务人员有权对我的孩子实施认定为合适的诊疗，包括但不限于预防性护理诊疗、体格检查、重复检查、患病诊疗、诊断检查、疫苗和注射、X 光、医疗试验，以及视为必要的任何药物处方：

(Print Name of adult)（用正楷填写成年人姓名）	(Print Relationship to child)（用正楷填写与儿童之间的关系）
(Print Name of adult)（用正楷填写成年人姓名）	(Print Relationship to child)（用正楷填写与儿童之间的关系）
(Print Name of adult)（用正楷填写成年人姓名）	(Print Relationship to child)（用正楷填写与儿童之间的关系）

Since the adult(s) named above are involved in my child's health care, I further authorize that the providers can give and discuss with the adult(s) protected health information (PHI) about my child and understand that the adult(s) listed above will be responsible for conveying any such PHI given by or discussed with the providers to me. I further authorize the release of PHI to the adult(s) named above concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/ psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions if any such information is contained in my child's medical record.

由于上述成年人会参与我孩子的医疗护理过程，我进一步授权医务人员能够向相关成年人提供有关我孩子的保密医疗信息(PHI)并与其讨论，而且我理解，由以上所列成年人负责将医务人员给予或与其讨论的相关PHI信息传达给我。我进一步授权，若我孩子的医疗记录中包含以下相关PHI信息，则可以将这些信息告知上述成年人：药物或酒精滥用、药物相关状况、嗜酒的诊疗，和/或精神/心理状况和/或精神/心理健康的诊疗，和/或艾滋病病毒 (HIV) 相关的状况。

This authorization is in effect for a period of one year from the date signed below unless revoked sooner.

本授权书自以下所签注的日期起一年内有效，除非在此之前被撤销。

______________________________ ____________________

(Signature of Parent/legal guardian) （家长/法定监护人的签字） (Date) （日期）

REVOCATION OF AUTHORIZATION

I agree that if at any time, I no longer want the providers to communicate with the adult(s) named above, or no longer want this authorization to be effective, I will immediately notify the office in writing by sending a letter to the address of Miami University Health Services 421 S. Campus Avenue, Oxford, Ohio 45056 addressed to Ms. Karen Kammer. The revocation will be effective 5 business days after receipt to allow time for processing. The revocation will be deemed a revocation of this authorization in its entirety. I understand that if I want to allow for any future authorization for treatment of my child, I will have to complete and sign a new authorization.

授权书的撤销

我同意，如果在任何时候我不再希望医务人员将相关信息告知上述成年人或不再希望此授权书生效，我将立即以书面方式通知事务所，具体方法为寄送信件到此地址：Miami University Health Services 421 S. Campus Avenue, Oxford, Ohio 45056，收件人为 Ms. Karen Kammer。撤销将于收到信件后的 5 个工作日后生效，以留出时间处理相关事宜。撤销操作将被视作是对本授权书完整内容的撤销。我理解，如果我希望在将来对我孩子的诊疗进行授权，我将需要填写并签署一份新的授权书。