加州專用/CALIFORNIA

UnitedHealthcare®

持續照護/Continuity of Care

什麼是持續照護？

新近投保會員的持續照護（簡稱 COC）是一種健保計畫程序，在某些情況下，讓會員在過渡至簽約醫療服務提供者時，於以前非簽約醫療服務提供者處（包括普通急性醫院）接受持續照護。此程序也適用於受到簽約醫療服務提供者（包括醫師和普通急性照護醫院）解約影響的現有會員。您從舊保險計畫過渡至新的 UnitedHealthcare of California (UnitedHealthcare) 計畫，或從解約醫療服務提供者過渡至 UnitedHealthcare 簽約醫療服務提供者時，持續照護程序起到「承保銜接」的作用。要獲得持續照護的資格，您必須一直在以下機構接受以下任一病況的受保服務：(i) 更改健保計畫時接受非簽約醫療服務提供者的受保服務，或 (ii) 在合約終止生效日接受解約醫療服務提供者的受保服務：

1. **急性病況**指的是一種涵蓋醫療及精神健康[1] 的醫療病況，涉及因疾病、傷害或其他需要立即診治且持續時間有限之病情所導致的突發病症。急性病況期間將提供完整的受保服務。
2. **嚴重慢性病況**指因疾病、身體不適或其他醫療或精神健康問題[2] 或醫療或精神健康[2] 障礙所引起的嚴重疾病，若未完若未完全治癒將持續存在，或漸趨惡化，或需要持續治療以緩和病情或避免惡化。完整受保服務將於完成現有療程以及安排安全轉診至簽約醫療服務提供者所需的期間內提供之，依照 UnitedHealthcare 醫療部主任與會員、(i) 解約醫療服務提供者、或 (ii) 非簽約醫療服務提供者，和接手簽約醫療服務提供者（如適用）商議並決定後，根據良好專業慣例提供之。完成這類病況的受保服務時間不會超過協議終止日起十二 (12) 個月或新近投保會員承保生效日起十二 (12) 個月。
3. **懷孕**指經由 (i) 解約醫療服務提供者在協議終止之前；或 (ii) 非簽約醫療服務提供者在新近投保會員的 UnitedHealthcare 承保生效日前，診斷與記錄為懷孕者。完成受保服務將於懷孕期間與產後初期提供之。
4. **臨終疾病**指很可能在一 (1) 年或更短時間之內造成死亡的不治之症或不可逆病況。臨終疾病期間會提供可能超過十二 (12) 個月的完整受保服務，前提是死亡預後必須經由：(i) 解約醫療服務提供者在協議終止日之前作出預後，或 (ii) 非簽約醫療服務提供者在新近投保會員的 UnitedHealthcare 承保生效日之前作出預後。

What is Continuity of Care?

Continuity of Care (COC) for newly enrolled Members is a health plan process that, under certain circumstances, provides Members with continued care with a former, Non-Participating Provider, including general acute Hospitals, while transitioning to a Participating Provider. It also applies to existing Members impacted by a Participating Provider (practitioners and general acute care Hospitals) termination. The COC process acts like a "bridge of coverage" as you transition from your old plan to your new UnitedHealthcare of California (UnitedHealthcare) plan or from a terminated Provider to a UnitedHealthcare Participating Provider. To qualify, you must have been receiving Covered Services from the (i) Non-Participating Provider at the time of the change in health plans or (ii) from the terminated Provider on the Effective Date of contract termination, for one of the following conditions:

1. **An Acute Condition** is a medical condition, including medical and mental health[1], that involves a sudden onset of symptoms due to an illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the Acute Condition.
2. **A Serious Chronic Condition** is a medical condition due to disease, illness, or other medical or mental health problem[2] or medical or mental health[2] disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Participating Provider, as determined by a UnitedHealthcare Medical Director in consultation with the Member, (i) the terminated Provider or (ii) the Non-Participating Provider and, as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's termination date or twelve (12) months from the Effective Date of coverage for a newly enrolled Member.
3. **A pregnancy** diagnosed and documented by (i) the terminated Provider prior to termination of the agreement, or (ii) by the Non-Participating Provider prior to the newly enrolled Member's Effective Date of coverage with UnitedHealthcare. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.
4. **A Terminal Illness** is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, which may exceed twelve (12) months, provided that the prognosis of death was made by the: (i) terminated Provider prior to the agreement termination date or (ii) Non-Participating Provider prior to the newly enrolled Member's Effective Date of coverage with UnitedHealthcare.

1 加州健康與安全法規第 1374.72 節規定者除外，精神健康的住院承保不屬於 UnitedHealthcare of California 的受保福利。/Except pursuant to the CA Health and Safety Code §1374.72, in-patient coverage for mental health is not a covered benefit under UnitedHealthcare of California.

2 針對僱主已經購買補充精神健康福利的會員，以及申請於解約或非簽約醫療服務提供者處接受加州健康與安全法規第 1374.72 節規定的「嚴重精神疾病」和「兒童嚴重情緒障礙」持續照護的會員，U.S. Behavioral Health Plan, California 將協調上述會員的持續照護。/U.S. Behavioral Health Plan, California will coordinate Continuity of Care for members whose employer has purchased supplemental mental health benefits and for members requesting continued care with a terminated or Non-Participating Provider for "serious mental illnesses" and "serious emotional disturbances of a child" as defined in CA Health and Safety Code §1374.72.

- 新會員若有機會選擇網絡外就醫，或曾有機會繼續健保計畫或繼續使用一醫療服務提供者，並且自願更改健保計畫，將不具接受持續照護的資格。/New Members do not qualify for Continuity of Care if the Member has been offered an out-of-network option, or had the option to continue with a Health Plan or Provider and voluntarily chose to change Health Plans.

5. **新生兒的照護：**指提供給剛出生至三十六 (36) 個月大子女的服務。完整受保服務從下列時間起算將不超過十二 (12) 個月：(i) 醫療服務提供者協議終止日；或 (ii) 新近投保會員的 UnitedHealthcare 承保生效日；或 (iii) 不超過子女的第三個生日後。
6. **外科手術或其他程序：**指 UnitedHealthcare 或會員的指定簽約醫療服務提供者已授權做為記錄療程的一部分，而且是由下列醫療服務提供者建議或記錄之：(i) 在協議終止日後 180 個日曆天內成為解約醫療服務提供者，或 (ii) 在新近投保會員的 UnitedHealthcare. 承保生效日後 180 個日曆天內成為非簽約醫療服務提供者。

當有下列情況時，由非簽約或解約醫療服務提供者治療中的持續照護病況的受保服務視同完成：

i. 會員治療中的持續照護病況從醫學角度而言已經穩定；以及
ii. UnitedHealthcare 的醫療部主任經與會員、診治非簽約或解約醫療服務提供者，以及會員的指定簽約醫療服務提供者 (如適用) 商議後，決定可以在沒有臨床禁忌的情況下，安全轉診至簽約醫療服務提供者。

此外，UnitedHealthcare 或您的指定醫療團體 / IPA 必須正式確定，在您的投保生效日或醫療服務提供者合約終止日更改醫療服務提供者會對您的健康造成不利影響。

持續照護還適用於：(i) UnitedHealthcare 承保生效當日在非簽約精神健康醫療服務提供者處接受精神健康照護服務的 UnitedHealthcare 新會員，或 (ii) 合約終止生效當日在解約精神健康醫療服務提供者處接受精神健康照護服務的現有會員。精神健康醫療服務提供者包括：精神病醫師、持照心理醫師、持照婚姻家庭諮商師或持照臨床社會工作者。

有資格接受持續精神健康照護服務的會員可在安全轉診至 UnitedHealthcare 簽約精神健康醫療服務提供者的合理期間內，持續接受診治非簽約或解約精神健康醫療服務提供者所提供的精神健康服務。欲知精神健康照護承保補充資訊，請參閱 UnitedHealthcare *綜合承保證明與透露表*中的醫療福利與「排除與限制」部分，以及*福利表* (若有)。欲知嚴重精神疾病 (SMI) 及兒童嚴重情緒障礙 (SED) 診斷治療的精神健康照護服務承保說明，請參閱*綜合承保證明與透露表*的行為健康補充文件。

5. **The care of a newborn:** Services provided to a child between birth and age thirty-six (36) months. Completion of Covered Services will not exceed twelve (12) months from the: (i) Provider agreement termination date, or (ii) the newly enrolled Member's Effective Date of coverage with UnitedHealthcare, or (iii) extend beyond the child's third (3rd) birthday.
6. **Surgery or Other Procedure:** Performance of a Surgery or Other Procedure that has been authorized by UnitedHealthcare or the Member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) terminating Provider to occur within 180 calendar days of the agreement's termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled Member's Effective Date of coverage with UnitedHealthcare.

Covered Services for the Continuity of Care condition under treatment by the Non-Participating or terminated Provider will be considered complete when:

i. the Member's Continuity of Care condition under treatment is medically stable; and
ii. there are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a UnitedHealthcare Medical Director in consultation with the Member, the treating non-participating or terminated Provider and as applicable, the Member's assigned Participating Provider.

In addition, a formal determination must be made by UnitedHealthcare or your assigned medical group/IPA that a change in Providers on your Effective Date of enrollment or the Provider termination date would have a negative effect on your health.

Continuity of Care also applies to (i) new UnitedHealthcare Members who are receiving mental health care services from a non-participating mental health Provider on their Effective Date of enrollment with UnitedHealthcare or (ii) to existing Members who are receiving mental health care services from a terminated mental health Provider, on the Effective Date of contract termination. A mental health Provider is any of the following: psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker.

Members eligible for continuity of mental health care services may continue to receive Mental Health Services from the treating non-participating or terminated mental health Provider for a reasonable period of time to safely transition care to a UnitedHealthcare Participating mental health Provider. Please refer to the Medical Benefits and the "Exclusions and Limitations" sections of your UnitedHealthcare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental mental health care coverage information, if any. For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form.*

誰授權持續照護？

如果您本人或您的家人目前正在接受上述任一病況的醫療照護，並且是經由您的前一健保計畫或解約醫療服務提供者授權，您有權利用適合的表格 (附表) 申請對持續照護進行臨床審查（*持續照護福利申請表*__*或*__*精神健康持續照護福利申請表*）。

若更改醫療服務提供者可能對您本人或您受撫養人的臨床照護造成不利影響，您可能取得由診治醫療服務提供者所提供的持續照護授權。會員對某一醫師或醫療服務提供者的偏好並不會賦予您接受持續照護福利的資格。如果您未獲得 UnitedHealthcare 或您的指定醫療團體 / IPA 的事先授權，您將負擔非簽約或解約醫療服務提供者提供之服務費用。

如果您認為您本人或您的家人具備接受持續照護的資格，請儘快填寫適用的的持續照護申請表並寄至 UnitedHealthcare，但不得超過以下時間起算三十 (30）個日曆天：(i) 您的 UnitedHealthcare 承保生效日，或 (ii) 您的診治醫療服務提供者解約生效日。除非有正當理由，否則以三十 (30) 個日曆天內寄回為佳。

收到填妥的表格後，UnitedHealthcare 健康服務部將進行臨床持續照護審查。將依據您的病況，及時地作出決定並將結果通知您。一般來說，非緊急的申請會在 UnitedHealthcare 收到填妥表格的五 (5) 個工作天內作出決定。我們將以電話通知您審查結果，並提供您持續照護的計畫。決定後的兩 (2) 個工作天內會透過美國郵局寄出決定及照護計畫的書面通知。如果您在診治醫療服務提供者處接受持續照護的申請被拒絕，書面通知將包括拒絕的理由以及您如何提出上訴的資訊。如果您對本程序有任何疑問，請致電 UnitedHealthcare 客戶服務部。

Who authorizes Continuity of Care?

If you or a member of your family is currently receiving medical care for one of the conditions as specified above that was authorized by your previous health plan, or the terminated Provider, you have the right to request a clinical Continuity of Care review by using the appropriate form, as attached *(Request for Continuity of Care Benefits* ***or*** *Request for Mental Health Continuity of Care Benefits).*

COC with your treating Provider may be authorized in those cases which a change in Provider could adversely affect you or your Dependent's clinical care. Member preference for a particular Physician or Provider will not qualify you for COC benefits. If you do not receive Preauthorization by UnitedHealthcare or by your chosen medical group/IPA, payment for services rendered by the non-participating or terminated Provider will be your responsibility.

If you think you or a member of your family qualifies for COC, complete the appropriate COC request form and forward it to UnitedHealthcare as soon as possible, but not later than thirty (30) calendar days of: (i) your Effective Date of enrollment with UnitedHealthcare or (ii) your treating Provider's Effective Date of termination. Exceptions to the thirty (30) calendar day time frame will be considered for good cause.

Upon receipt of the completed form, UnitedHealthcare's Health Services department will complete a clinical COC review. The decision will be made and communicated to you in a timely manner appropriate for the nature of your condition. In most instances, decisions for non-urgent requests will be made within five (5) business days of UnitedHealthcare's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will also be sent to you by United States mail, within two (2) business days of making the decision. If your request for continued care with your treating Provider is denied, the written notice will include the reason(s) for the determination and information about how you can appeal the decision. If you have any questions about this process, please call the UnitedHealthcare Customer Service department.

P.O. Box 30968
Salt Lake City, UT 84130-0968

客戶服務專線：/
Customer Service:
800-624-8822
800-422-8833 (聽障專線/TDHI)
www.uhcwest.com

加州專用/CALIFORNIA

申請持續照護福利/ Request for Continuity of Care Benefits

請填妥整份表格。/Please complete the entire form.

投保人與計畫資訊/Subscriber and Plan Information

投保人姓名/Subscriber Name	會員卡號碼 (若知道)/ID# (if known)	社會安全號碼/Social Security #	
地址/Address	城市/City	州/State	郵遞區號/ZIP
目前的 UnitedHealthcare 計畫類型/ Type of Current UnitedHealthcare Plan □ HMO □ POS □ 其他/Other:	目前 UnitedHealthcare 計畫的生效日期 (若適用)/Effective Date of Current UnitedHealthcare Plan (if applicable):	住家電話號碼/Home Phone	工作電話號碼/Work Phone
僱主名稱/Employer Name	僱主團體號碼/Employer Group #	前一保險 (若適用)/ Prior Insurance (if applicable)	前一醫療團體 / IPA 或解約醫療服務提供者 (若適用) / Prior Medical Group/IPA or Terminated Provider (as applicable)

病患、醫師及治療資訊/Patient, Physician and Treatment Information

病患姓名/Patient Name	與投保人的關係/Relation to Subscriber	生日/Date of Birth	電話號碼/Phone
通訊地址 (如與投保人不同)/Address (if different from Subscriber)			
目前診治醫師或醫療服務提供者/ Present Treating Physician or Provider	診治醫師 / 醫療服務提供者電話號碼/ Treating Physician's/Provider's Phone	診治醫師專科/Treating Physician's Specialty	
診治醫師 / 醫療服務提供者地址/Treating Physician's/Provider's Address			
醫師 / 醫療服務提供者治療病患的時間有多長?/ How long has Physician/Provider been treating Patient?	預計分娩日期 (若適用)/ Expected Date of Delivery (if applicable)	醫院 (若適用)/Hospital (if applicable)	
新的主治醫師或醫療團體 / IPA (選自 UnitedHealthcare 醫療服務提供者名錄)/ New Primary Care Physician or Medical Group/IPA (selected from UnitedHealthcare Provider List)			
疾病性質 / 意見 (描述正在接受治療的病況。包括診斷情況、預計治療持續期間以及手術日期 (若已經安排)。) 若空間不夠，請另行加頁。/ Nature of Illness/Comments (Describe condition being treated. Include diagnosis, expected treatment duration and dates of surgery if scheduled.) Please use a separate sheet for additional comments.			

- **說明：**使用與公開醫療資訊的授權要求您遵守 1981 年醫療資訊法案保密條款以及民法規第 56 節及以下章節的條款。請注意，如果您申請的是與精神健康或物質濫用相關治療的持續照護福利，您將填寫另外的授權表格，以遵循聯邦法律和州法律嚴格保護此類治療記錄的規定。如果您申請的不是與精神健康或物質濫用相關治療的持續照護福利，您應填妥本表格並寄回 UnitedHealthcare，郵寄地址：CA124-0181, P.O. Box 30968, Salt Lake City, UT 84130-0968, Attn: Continuity of Care Department。**請傳真至 UnitedHealthcare, Continuity of Care Department，傳真號碼為 1-888-361-0514。/Explanation:** This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. Please note that if you are requesting Continuity of Care Benefits for treatment relating to mental health or substance abuse, you will be provided with separate authorization forms which have been adopted to comply with the heightened protections for these treatment records afforded by federal and state laws. If you are not requesting Continuity of Care Benefits for treatment relating to mental health or substance abuse, you should complete this form and return it to UnitedHealthcare, Mail Stop: CA124-0181, P.O. Box 30968, Salt Lake City, UT 84130-0968, Attn: Continuity of Care Department. **Fax transmissions may be directed to UnitedHealthcare, Continuity of Care Department, 1-888-361-0514.**
- **授權：**本人特此授權 (醫師、醫院或健康照護提供者的名稱)__________________ 向 UnitedHealthcare of California 提供與 (病患姓名)__________________ 的病歷、病況、接受的服務或治療相關的病歷與資訊。/ **Authorization:** I hereby authorize (name of Physician, Hospital or health care Provider)________________ to furnish to UnitedHealthcare of California medical records and information pertaining to medical history, medical condition, services rendered or treatment of (name of patient) ______________________________
- **限制條件：**本授權不適用於精神健康和 (或) 物質濫用記錄的公開。/**Limitations:** This authorization does not apply to the release of mental health and/or substance abuse records.
- **用途：**本資訊僅限 UnitedHealthcare of California 使用，以評估持續照護福利申請。/**Uses:** This information will be used solely by UnitedHealthcare of California in order to evaluate the request for Continuity of Care Benefits.
- **持續時間：**本授權應立即生效，並持續有效至 (日期)__________ , __________。/**Duration:** This authorization shall become effective immediately remain in effect until (date) ____________ , _______ .

- **限制：**本人瞭解 UnitedHealthcare of California 不得進一步地使用或透露醫療資訊，除非獲得我的另外授權，或法律對此類使用或透露有具體要求或許可。/**Restrictions:** I understand that UnitedHealthcare of California may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
- **額外複本：**本人還瞭解，如有需要，我有權獲得本授權書的複本。/**Additional Copy:** I further understand that I have a right to receive a copy of this authorization upon my request.
  已索取複本/Copy requested: □ 是/Yes □ 否/No **請簽上姓名首字母/Initial:** ____________________

請以正楷書寫病患姓名/Print Name of Patient	日期/Date	時間/Time □ 上午/A.M. □ 下午/P.M.
病患簽名（如果病患為未成年人或無行為能力，父母簽名或法定代理人簽名）/ Patient's Signature (if patient is a minor or incompetent, parent's signature or signature of legal representative)		

如果您需要精神健康持續照護申請表，或有關於持續照護福利的任何疑問，請聯絡 UnitedHealthcare 的客戶服務部：UnitedHealthcare SignatureValue™ (HMO) 會員請撥 1-800-624-8822，聽語障人士請撥 TTY/TDD 專線 1-800-422-8833。/If you need a mental health COC request form, or have any questions regarding your COC benefits, please contact UnitedHealthcare's Customer Service department at 1-800-624-8822 for UnitedHealthcare SignatureValue® (HMO) members and the hearing- and speech-impaired may call TTY/TDD 1-800-422-8833.

將本表傳真至 1-888-361-0514 或折疊後寄出。/
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PCA400302-001

加州專用/CALIFORNIA

UnitedHealthcare®

精神健康持續照護福利申請/ Request for Mental Health Continuity of Care Benefits

請填妥整份表格。/Please complete the entire form.

投保人與計畫資訊/Subscriber and Plan Information

投保人姓名/Subscriber Name	會員卡號碼 (若知道)/ID# (if known)	社會安全號碼/Social Security #	
地址/Address	城市/City	州/State	郵遞區號/ZIP
目前的 UnitedHealthcare 計畫類型/ Type of Current UnitedHealthcare Plan ☐ HMO ☐ POS ☐ 其他/Other:	目前 UnitedHealthcare 計畫的生效日期（若適用)/Effective Date of Current UnitedHealthcare Plan (if applicable):	住家電話號碼/Home Phone	工作電話號碼/Work Phone
僱主名稱/Employer Name	僱主團體號碼/Employer Group #	前一保險 (若適用)/Prior Insurance (if applicable)	前一醫療團體 / IPA 或解約醫療服務提供者 (若適用)/ Prior Medical Group/IPA or Terminated Provider (as applicable)

病患、醫師及治療資訊/Patient, Physician and Treatment Information

病患姓名/Patient Name	與投保人的關係/Relation to Subscriber	生日/Date of Birth	電話號碼/Phone
通訊地址 (如與投保人不同)/Address (if different from Subscriber)		目前的診治精神健康醫療服務提供者/Present Treating Mental Health Provider	
診治醫療服務提供者電話號碼/Treating Provider's Phone	診治醫療服務提供者通訊地址/Treating Provider's Address	醫師 / 醫療服務提供者治療病患的時間有多長?/ How long has Physician/Provider been treating Patient?	
醫院 (若適用)/Hospital (if applicable)	新的主治醫師或醫療團體 / IPA (選自 UnitedHealthcare 醫療服務提供者名錄)/ New Primary Care Physician or Medical Group/IPA (selected from UnitedHealthcare Provider List)		
疾病性質/意見（描述正在接受治療的病況。包括診斷以及預計治療持續期間）若空間不夠，請另行加頁。/ Nature of Illness/Comments (Describe condition being treated. Include diagnosis and expected treatment duration) Please use a separate sheet for additional comments.			

- **說明：**使用與公開醫療資訊的授權要求您遵守 1981 年醫療資訊法案保密條款以及民法規第 56 節及以下章節的條款。請注意，如果您申請的是與精神健康或物質濫用相關治療的持續照護福利，您將填寫另外的授權表格，以遵循聯邦法律和州法律嚴格保護此類治療記錄的規定。如果您申請的不是與精神健康或物質濫用相關治療的持續照護福利，您應填妥本表格並寄回 UnitedHealthcare，郵寄地址：CA124-0181, P.O. Box 30968, Salt Lake City, UT 84130-0968, Attn: Continuity of Care Department。**請傳真至 UnitedHealthcare, Continuity of Care Department，傳真號碼為 1-888-361-0514。/Explanation:** This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. Please note that if you are requesting Continuity of Care Benefits for treatment relating to mental health or substance abuse, you will be provided with separate authorization forms which have been adopted to comply with the heightened protections for these treatment records afforded by federal and state laws. If you are not requesting Continuity of Care Benefits for treatment relating to mental health or substance abuse, you should complete this form and return it to UnitedHealthcare, Mail Stop: CA124-0181, P.O. Box 30968, Salt Lake City, UT 84130-0968, Attn: Continuity of Care Department. **Fax transmissions may be directed to UnitedHealthcare, Continuity of Care Department, 1-888-361-0514.**
- **授權：**本人 (病患姓名）_____________ 特此授權 (獲得授權以公開指定資訊的責任者姓名，例如醫師或負責照護病患的持照人員，或計畫的管理者） _____________ 向 UnitedHealthcare 透露在診斷和治療我的精神健康相關病況的過程中獲得的資訊和記錄。/**Authorization:** I, (name of patient) _____________ hereby authorize (name of responsible individual who has authorization to release information specified, e.g., physician or other licensee in charge of the patient, or administrator of program) _________________ to disclose information and records obtained in the course of my diagnosis and treatment for a mental health related condition to UnitedHealthcare.
- **透露限制：**本透露授權應僅限於一次透露，並限於以下類型的資訊：與 (病患姓名）________ 的病史、病症、接受的服務或治療相關的病歷與資訊。在以下空白處說明可公開資訊的限制。/ **Limitations on Disclosure:** This disclosure authorized herein shall be limited to a one-time disclosure only and shall be limited to the following types of information: medical records and information pertaining to medical history, medical condition, services rendered, or treatment of (name of patient) ________________________ . Use the following space to indicate any limitations on the information which can be released.
- **資訊使用的限制：**授權透露的資訊與記錄僅供 UnitedHealthcare 用於評估我的持續照護福利申請。若 UnitedHealthcare 另外使用或進一步透露此類資訊，必須獲得另外的授權，除非法律對此類使用或透露有具體要求或許可。/ **Restrictions on Use of Information:** The information and records authorized for disclosure herein are to be used solely by UnitedHealthcare to evaluate my request for Continuity of Care Benefits. A separate authorization must be obtained for any separate use or further disclosure of this information by UnitedHealthcare, unless such use or disclosure is specifically required or permitted by law.
- **授權表複本：**本人瞭解，獲得授權公開本表規定資訊的人士應向我提供本授權表的複本。**請簽上姓名首字母：** _____ /**Copy of Authorization Form:** I understand that a copy of this authorization form should be provided to me by the individual who has been authorized to release the information specified herein. **Initial:** _______

請正楷書寫病患姓名/Print Name of Patient	日期/Date	時間/Time □ 上午/A.M. □ 下午/P.M.
病患簽名 (如果病患為未成年人或無行為能力，父母簽名或法定代理人簽名)/ Patient's Signature (if patient is a minor or incompetent, parent's signature or signature of legal representative)		

Lanterman-Petris-Short 法案規定的公開/Release Under Lanterman-Petris-Short Act

- **說明：**如果您是在醫療機構接受的精神健康治療，而不是私人醫師提供的精神病治療服務或諮商服務，以下部分應由您的健康照護提供者填寫。於醫療機構接受的治療包括下列：設有照護和治療精神病患的部門或病房的私人機構、醫院、診所或療養院的自願治療；在州立醫院或郡立精神病醫院的自願治療；或任何類型的非自願治療。/**Explanation:** The following section should be completed by your health care provider if you received mental health treatment in an institutional setting, as opposed to psychiatric or counseling services provided by a private physician. Treatment in an institutional setting includes the following: voluntary treatment in a private institution, hospital, clinic or sanitarium, which includes a department or ward for the care and treatment of persons who are mentally disordered; voluntary treatment in a state hospital or county psychiatric hospital; or involuntary treatment of any kind.

以下簽名者、醫師、持照心理醫師或負責照顧病患且持有社會工作碩士學位的社工人員，特此 □ 同意 □ 不同意 向上述指定機構公開資訊和記錄。
如果不同意透露，請在下面說明理由。同時在下面註明病歷公開的任何限制。____/
The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, who is in charge of the patient, hereby □ approves □ disapproves the release of information and records to the party specified about. If disclosure is disapproved, give reasons below. Also note below any restrictions on the release of records. ____

日期/Date	簽名 (醫師 / 心理醫師 / 社工人員)/Signature (physician/psychologist/social worker)	學位/Degree

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