Patient Identification Number A10_____

Montgomery County Department of Health & Human Services

Asian American Health Initiative

Hepatitis B Project

Consent Form 同意書

*請用英文填寫本同意書 Please fill out this consent form in English

姓名Name _____

姓氏Last　　名字First

住址Address _____

街道Street　　城市City　　郵遞區號 Zip Code

電話Phone (_____) _____　　出生日期Date of Birth： __ __ / __ __ /__ __ __ __

月Month / 日Day / 年Year

同意及豁免協議Consent and Release Agreement

我瞭解以下事項I understand that:

1. Lab Corp 人員將會抽取我的血液，並進行乙型肝炎病毒篩檢。檢測後，實驗室報告會寄送給亞裔美國人健康促進協會 (AAHI) 的醫師志工進行審核。My blood will be drawn by Lab Corp staff and screened for Hepatitis B virus. The lab report will then be sent to an Asian American Health Initiative (AAHI) volunteer physician for review.
2. 抽血可能導致出血、瘀傷或疼痛，有些人會暈眩、感到頭昏眼花或昏厥。抽血也有感染的風險，但機率很低。The blood draw may cause bleeding, bruising, or pain. Some people become dizzy, feel faint, or faint. There is a rare risk of infection because of blood drawing.
3. 篩檢並非診斷，且可機會忽略需要進一步篩檢方能偵測的異常狀況。此外，有時篩檢顯示的異常，經由進一步檢測後卻可能證實爲正常。These screenings are not diagnostic and may miss abnormalities, which further testing would detect. Also, on occasion, these screenings may show abnormalities that further testing will prove to be normal.
4. 血液檢測的結果會寄送給疾病管制局 (CDC) 及負責協助 CDC 收集乙型肝炎資料的北卡三角洲國際研究院 (RTI International)。AAHI 的乙型肝炎試行計畫評估報告中亦將使用您的血液檢測結果，但不會提及任何足以識別個人身份的資料。The results of the blood test will be sent to the Centers for Disease Control and Prevention (CDC) and RTI International, which collects Hepatitis B data for the CDC. It will also be utilized by AAHI in a report to evaluate the Hepatitis B Pilot Project but no identifying data will be used.
5. 我已閱讀、瞭解並接受隨附手冊中所述的試行計畫範圍之條款。I have read, understood and accept the terms of the scope of the pilot project in the accompanying brochure.
6. 我保證我在註冊表單上提供的聲明及資訊完整且真實。I certify that the statements and information I have given on my registration form are true and complete.

茲聲明本人豁免亞裔美國人健康促進協會、其授權對象、贊助者、員工、代理機構、代表、董事會及任何與此篩檢相關的個人或實體，承擔可能因此篩檢和 / 或其衍生資料和 / 或散佈之任何資訊所產生的任何和所有賠償責任。I, the undersigned, release the Asian American Health Initiative, its licensees, funders, employees, agents, representatives, Board of Directors, and any individual or entity associated with this screening from any and all paid liability which may arise from these screenings and/or data derived from it and/or from any information distributed.

除本人於此同意書中授權之豁免資訊外，提供給亞裔美國人健康促進協會之全部資訊均將保密，且除非與「隱私權施行通告」中載明的 HIPAA (醫療保險可攜性和責任法案) 一致之馬里蘭州或聯邦法律允許或要求，否則不得再次向其他人揭露。Except for the release of information that I have authorized in this consent form, all information given to the Asian American Health Initiative will be kept confidential and will not be disclosed again to others except as allowed or required by Maryland or Federal law consistent with HIPAA (Health Insurance Portability and Accountability Act) as specified in the Notice of Privacy Practices.

我已閱讀並瞭解上述同意及豁免協議，並願意依照協議中包含之條款進行此篩檢。除非本人撤銷，否則本同意書持續有效。I have read and understand the above Consent and Release Agreement and desire to have such screenings pursuant to the terms contained herein. This consent form remains in place unless revoked by me.

_____ _____ _____ _____

簽名Signature　　日期 Date　　見證人簽名Witness Signature　　日期Date

*Chinese Translation for reference only 中文譯本只供參考 英文English/中文Traditional Chinese