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***北卡羅來納州嬰幼兒計畫****(North Carolina Infant Toddler Program, NC ITP)*

***限制使用和揭露健康資訊請求***

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| 身分識別 | | | | | | | | | | | | | | | |
| 兒童姓名： |  | | | 出生日期： | |  | | | | 兒童的社會安全號碼（選填）： | | | | |  |
|  | | | | | | | *月/日/年* | | | | | | | | |
| 家長/法定監護人地址： | | |  | | | | | | | | | | | | |
|  | | | | |  | | |  | | | |  | |  | |
| 街道 | | | | | 公寓號碼 | | | 城市 | | | | 州 |  | 郵遞區號 | |
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| 家長/法定監護人住家電話號碼 | |  | | | | | | | 工作電話號碼 | |  | | | | |
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| 請求 | | | | | | | | | | | | | | | |
| **本人了解本人可以要求限制本人子女的健康資訊用作特定用途及限制揭露本人子女的健康資訊。因此，本人特此要求在下列情況下，限制使用和揭露由此機構或提供者建立或保留的本人或本人子女的健康資訊：** | | | | | | | | | | | | | | | |
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| 家長/法定監護人簽名 |  | 日期 |
|  |  |  |
| 法定監護人關係/權限 |  | |

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| ***本欄僅供機構使用*** | | | | | |
| 請求已核准 | | | | | |
| 機構要求 | 員工限制事項通知 | | | | |
|  | 視需要通知其他機構 | | | | |
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| 請求遭拒絕 |  | | | | |
| 拒絕原因： | 可能會妨礙或延誤有效治療。 | | | | |
|  | 法律規定的揭露 | | | | |
|  | 其他 | | | | |
|  | |  |  |  |  | |
| 工作人員簽名 | |  | 職稱 |  | 日期 | |
|  | | | | | | |