

名條貼紙
Name tag

成大醫院皮膚部

Department of Dermatology, National Cheng-Kung University Hospital

臨床照片紀錄及使用同意書

Consent for clinical photos for medical record and use

為因應醫療、教學、研究及健保審查申報需要，本人同意_____醫師在以下情況下，於手術(醫療)前、手術(醫療)後及手術(醫療)過程中施行必要之照相記錄。

Due to medical treatment, teaching, research and National Health Insurance evaluation, I hereby authorize Dr. _____ under following circumstances, obtain necessary photographic records before, during, and after operation/treatment.

一、 所有上述紀錄必須由立同意書人之主治醫師及其團隊人員來執行照相作業。

1. All above mentioned records must be obtained by the signee's attending physician and his/her medical team.

二、 立同意書人允許將上述紀錄運用於教學、研究、醫療科技發展、醫學會議、醫學期刊發表及健保審查申報等目的上。

2. The signee authorizes above mentioned records to be used in purposes of teaching, research, medical treatment and technology development, medical conferences, medical journal publication and National Health Insurance evaluation.

三、 醫師將不會因立同意書人同意授權與否而影響任何的醫療行為。

3. The decision to authorize or not will not affect any medical decision or treatment by the physician.

四、 本部將善盡職責確保您的隱私，並妥管理所有照片記錄

4. The department will ensure full responsibility for the privacy and management of all signee's photographic records.

立同意書人 (Name) : _____ 身份證字號 (ID No) : _____

電話 (Tel) : _____ 日期 (Date) : 西元_____年 (y)____月(m)____日(d)

由父母親或監護人同意授權

Authorization by parent or guardian

我是病人_____的家長/監護人，本人代表簽立此授權書已同意上述所列的一切。

I am the parent/guardian of _____, I hereby agree to the above mentioned statements in this authorization.

家長/監護人 (Parent/Guardian) : _____ 身份證字號 (ID No) : _____

電話 (Tel) : _____ 日期 (Date) : 西元_____年 (y)____月(m)____日(d)