3600

Providence SWEDISH

Codsiga Bukaanka ee Helitaanka/Shaacinta Diwaan Gaar ah
Patient Request to Access/Disclose a Designated Record Set (Somali)

Buuxinta dhukumiintigan waxay ogolaanaysaa shaacinta iyo/ama isticmaalka macluumaadka caafimaadka kugu saabsan. Ku guuldaraysiga bixinta dhamaan macluumaadka la codsaday waxay burin kartaa ogolaanshahan. / Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

FIIRO GAAR AH: Haddii aad tahay bukaan/wakiilka bukaan oo codsanaya diiwaanada caafimaadka ee isticmaalka shakhsi ahaaneed, waxaa laga yaabaa in lacag lagu bixiyo soo saarista diiwaanada caafimaadka. / NOTE: If you are a patient/patient representative requesting medical records for personal use, there may be a fee for production of the medical records.

Macluumaadka lagu codsaday Codsiga Bukaan-socodka ee Helitaanka/Shaacinta Diiwaanka La Qorsheeyay waxay ku saleysan tahay shuruudaha gobolka iyo kuwa dawlada dhexe labadaba. / Information requested in this Patient Request to Access/Disclose a Designated Record Set is based on requirements by both state and federal regulations.

Waxaad ku lifaaqi kartaa bog dheeraad ah haddii loo baahdo qolal kabban inta lagu bixiyay foomka codsiga.
Haddii aad u codsanayso diiwaanada bukaanka dhintay, fadlan soo gudbi nuqulka cadaynta dhimashada; nuqulka Awooda Lagu Siiyay Qareenka, aaminaada ama dardaaranka, haddii la heli karo; ruqsada darawalnimada ee qofka codsanaya diiwaanada caafimaadka; oo ay la socoto foomka codsiga oo la buuxiyay. / You may attach an additional page if more room is needed than provided on the request form. If you are requesting records for a deceased patient, please submit a copy of the death certification; copy of Power of Attorney, trust or will, if available; driver's license of person requesting medical records; along with the completed request form.

Fadlan u gudbi foomkan / Please forward this form to:

Hospital Medical Record Requests ONLY to:
Swedish Medical Center
Release of Information Department
747 Broadway, Seattle, WA 98122
Iimaylka: ROI@swedish.org
Talefoonka: (206) 320-3850 • Faakis: (206) 320-2626

Swedish Medical Group Requests ONLY to:
Iimaylka: smgroi-wa@datavant.com
Talefoonka: (206) 320-3025 • Fakiska: (478) 238-9436

Fadlan Ogaw: Swedish Medical Center/Group/Swedish Medical Group (SMC/SMG) hada ma daabacdo ama ma shaacin karto lambarada bulshada ee sooshal sukuuratiga ee bukaanka ilaa looga baahdo biilasha. Si kastaba ha ahaatee, lambarada sooshal sukuuratiga ayaa laga yaabaa in lagu daro diiwaanada caafimaadka ee ka weyn dhowr sano. / Please Note: SMC/SMG no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in medical records that are more than a few years old.

Diiwaanada caafimaadka ee aad codsanayso waxaa laga yaabaa in aan la heli karin sababo la xiriira shuruudaha sii haynta gobolka. / Medical Records you are requesting may not be available due to the state retention requirements.

Macluumaadka la shaaciyay iyadoo la raacayo ogolaanshahan waxaa dib u shaacin kara qofka helaya. Dib u shaacinta oo kale xaaladaha qaarkood ma ilaalinayo sharciga gobolka waxaana laga yaabaa in aan lagu ilaalin sharcigaasturnaanta ee dawlada dhexe (Health Insurance Portability and Accountability Act, HIPAA). / Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

ATTENTION: Haddii aadan ku hadlin Ingiriisi, waxaad heli kartaa adeegyada kaalmada luuqada oo lacag la'aan ah. Wac 888-311-9127 (Swedish Edmonds 888-311-9178) (TYY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中文翻譯服務, 請致電 888-311-9127 (TYY: 711)

CODSIGA BUKAANKA EE HELITAANKA/SHAACINTA DIWAAN GAAR AH

PATIENT REQUEST TO ACCESS/DISCLOSE A DESIGNATED RECORD SET (SOMALI)

SHARAXAADA / EXPLANATION:

Ogolaanshahan waxaa lagaa codsanayaa inaad u hogaansanto shuruucda gobolka iyo dawlada dhexe.

Magaca Bukaanka: Patient's Name:	**Taariikhda Dhalashada:** Date of Birth	
Magacyo Hore oo la Isticmaalay: Prior Name(s) Used:	**Talefoonka #:** Phone #:	
Ciiwaanka Bukaanka: Patient's Address:		
Magaalo: City:	**Gobol:** State:	**Boosta:** Zip Code:
Cinwaanka limaylka: Email Address:_____ @ _____		

ISTICMAALKA IYO SHAACINTA MACLUUMAADKA CAAFIMAADKA / USE AND DISCLOSURE OF HEALTH INFORMATION:

Waxaan halkan ku ogolaanaya SMC/SMG inay u shaaciyaan diiwaankayga caafimaad: / I hereby authorize SMC/SMG to release my medical records to: ☐ **Aniga AMA** (Myself) ☐ **Qofka helaya ee hoos ku qoran** (Recipient listed below):

Magaca Qofka Helaya: Recipient's Name:	**Attention:**	
Ciiwaanka Qofka Helaya: Patient's Address		
Magaalo: City:	**Gobol:** State:	**Boosta:** Zip Code:
Talefoonka: Phone #:	**Fakis / Fax:**	
Ikhtiyaarka u gaynta / Delivery Option**:** ☐ **MyChart** ☐ **Warqad (Boostada lagu diro) /** Paper (Mailed) ☐ **CD (Boostada lagu diro) /** CD (Mailed) ☐ **FAKIS / FAX** ☐ **limaylka /** Email**:** _____@_____		

MACLUUMAADKA LA SHAACINAYO / INFORMATION TO BE RELEASED :

Waxaan macluumaadka ka codsanayaa Ibitaalka(ada) soo socda / I am requesting information from the following Hospital(s)**:**

Liistada Isbitaalka(ada) / List Hospital(s)	**Sheeg Taariikhda Daawaynta /** Specify the Dates of Treatment

MACLUUMAADKA LA SHAACINAYO (Kaliya sax hal sanduuq oo qaybtan ah) / INFORMATION TO BE RELEASED:

☐ **Macluumaadka la xiriira (Tani waa waxa bukaanada iyo dhakhaatiirta intooda badani u baahan yihiin). Soo koobitaanka Bixinta, Warbixinta Waaxda Xaaladaha Degdega ah, Taariikhda iyo Jirka, La-talinta, Warbixinada Qaliin, Shaybaarada, Warbixinada Raajada, Electroencephalogram (EEG), Electromyogram (EMG), Electrocardiogram (EKG), Warbixinnada Baaritaanka. (Waxaa laga yaabaa in lacag laga qaado) /** Pertinent information

☐ **Dhammaan/Guud ahaan Diiwaanka Caafimaadka (Waxa ku jira macluumaadka la xiriira iyo dhamaan dhukumiintiyada kale ee ku jira diiwaanka caafimaadka) /** All/Entire Medical Record **(Includes pertinent information plus all other documentation in the medical record)** (A fee may be charged)

☐ **Mid kale (sheeg) /**Other (specify)**:** _____

☐ **Labadii sano ee la soo dhaafay oo kaliya (Sheeg xirmada daabacaada) /** Last two years only **(Specify print package):**

☐ **Macluumaadka La Xiriira /** Pertinent Information ☐ **Dhamaan/Guud ahaan Macluumaadka Caafimaadka** All/Entire Medical Record

OGOLAANSHO DHEERAAD AH AYAA LA CODSADAY MIDAN SHRCIGA GOBALKA/DAWLADA DHEXE AWGOOD: ADDITIONAL AUTHORIZATION REQUIRED:

Waxaan si gaar ah u ogolaaday shaacinta macluumaadka soo socda (sax, xarafka ugu horeeya magaca iyo taariikhda sida ku haboon) / I specifically authorize release of the following information **(check, initial and date as appropriate)**:

☐ **Macluumaadka daawaynta caafimaadka dhimirka** / Mental Health treatment information	**Xarafka ugu horeeya Magaca ee Taariikhda:** / Initial and Date:
☐ **Natiijooyinka baaritaanka HIV /** HIV test results	**Xarafka ugu horeeya Magaca ee Taariikhda:** / Initial and Date:
☐ **Macluumaadka daawaynta khamriga/daroogada** / Alcohol/drug treatment information	**Xarafka ugu horeeya Magaca ee Taariikhda:** / Initial and Date:
☐ **Cudurka Galmada Lakala Qaado (WA Kaliya) /** Sexually Transmitted Disease (WA Only)	**Xarafka ugu horeeya Magaca ee Taariikhda:** / Initial and Date:

UJEEDADA / PURPOSE:

Ujeedada isticmaalka ama shaacinta loo codsaday / Purpose of requested use or disclosure**:** ☐ **Codsiga Bukaanka /** Patient Request ☐ **Daryeelka oo Sii Socda** /Continuing Care ☐ **Sharci /** Legal ☐ **Caymiska** /Insurance ☐ **Mid kale /** Other**:** _____

WAKHTIGA DHICITAANKA / EXPIRATION:

Oggolaanshahani wuu dhacayaa (Taariikhda) /This Authorization expires (Date) _____

Haddii aan Taariikh la bixin, ogolaanshahani wuxuu dhacayaa lix bilood gudahood laga bilaabo taariikhda saxeexa. / If no Date is given, this authorization will expire in six months from the signature date.

XUQUUQAHAYGA / MY RIGHTS:

Waxaa laga yaabaa inaan diido inaan saxeexo ogolaanshahan. Haddii aan diido in aan saxeexo ogolaanshahan, waa in aan ogaado in sharci ahaan, macluumaadkayga caafimaad aan la shaacin karin. Diidmadaydu wax saamayn ah kuma yeelan doonto awoodayda aan ku heli karo daawaynta ama lacag bixinta ama u-qalmitaanka dheefaha. / I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

Waxa laga yaabaa in aan kormeero ama helo nuqul xogta caafimaadka ee la iga codsanayo in aan ogolaado in la isticmaalo ama la shaaciyo. Waan ka noqon karaa ogolaanshahan wakhti kasta, laakiin waa inaan sidaas ku sameeyaa qoraal oo aan u gudbiyaa ciwaanka deegaanka ee soo socda / I may inspect or obtain a copy of the health information that I am being asked to allow the use or dis- closure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address**:**

Providence St. Joseph Health
Health Information Release of Information/Revoke Authorization
P.O. Box 4950
Portland, OR 97208

Ka noqoshadaydu waxay dhaqangali doontaa marka la helo, marka laga reebo ilaa xad in kuwa kale ay dhaqan galiyeen tiiritaanka ogolaanshahan. / My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Waxaan xaq u leeyahay in aan helo nuqulka ogolaanshahan. / I have a right to receive a copy of this authorization.

Macluumaadka la shaaciyay iyadoo la raacayo ogolaanshahan waxaa dib u shaacin kara qofka helaya. / Information disclosed pursuant to this authorization could be re-disclosed by the recipient. **Dib u shaacinta oo kale xaaladaha qaarkood ma ilaalinayo sharciga gobolka waxaana laga yaabaa in aan lagu ilaalin sharcigaasturnaanta ee dawlada dhexe (HIPAA). /** Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

SAXEEXA / SIGNATURE:

Saxeexa Bukaanka: Patient Signature:	**Taariikhda/** Date:
Saxeexa Wakiilka Sharcia ah: (Wakiilka bukaanka/lamaanaha) Legal Representative Signature: (Patient representative/spouse)	**Taariikhda/** Date:

Haddii uu saxeexo qof aan bukaanka ahayn, sheeg xiriirka sharci ee bukaanka kala dhexeeya oo fadlan bixi, tusaale ahaan, nuqulka dhukumiintiga mataalada qareenka (Durable Power of Attorney, DPOA), Shahaadada Dhimashada,

Masuulnimada / If signed by someone other than the patient, state your legal relationship to the patient and please provide, i.e, copy of DPOA, Death Certificate, Guardianship:

Xiriirka kaala dhexeeya bukaanka: Relationship to Patient:	**Taariikhda/** Date:

Iyada oo ku xiran Xeerarka Gobolka, ogolaanshaha dhakhtarka ka soo qaybgalay bukaanka mudada ay joogaan ayaa laga yaabaa in loo baahdo. / Dependent on State Regulations, authorization from the physician who attended the patient during their stay may be required.

HOSPTIAL USE ONLY

PHYSICIAN RELEASE OF MEDICAL RECORD

☐ APPROVED by Physician Name: _____ Date: _____ HIM-ROI CG Initials: _____

☐ DENIED – REASON FOR DENIAL: _____

MD Signature: _____ Date: _____ Time: _____