



DALABKA BUKAANKA EE GELITAANKA DUWAANKA GAARKA AH PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET (SOMALI)

Meelaha qaarkood, Swedish Health Services iyo kooxaha raacsan waxa laga yaabaa inay ku kaydiyaan rikoorada caafimaad ee bukaanka si ka gaar ah rikoorada cusbitaalka bukaanka. Waan ku faraxsaan lahayn inaan fakis ugu dirno koobiga foomkan goobaha kale ee laga codsado.

In some areas, Swedish Health Services and affiliates may store patient clinic records separately from patient hospital records. We would be glad to fax a copy of this form to other facilities upon request.

Waxaad ku lifaaqi kartaa bog dheeraad ah haddii loo baahdo qolal kabban inta lagu bixiyay foomka codsiga. You may attach an additional page if more room is needed than provided on the request form.

**Fadlan u gudbi foomkan mid kamid ah goobahan, iyadoo ku xidhan halka aad daryeelka ka heshay:
Please submit this form to one of these locations, depending on where you received care:**

<p align="center">Swedish Medical Center</p> <p align="center">Release of Information</p> <p align="center">747 Broadway, Seattle, WA 98122</p> <p align="center">Taleefanka/ Phone: (206) 320-3850</p> <p align="center">Fakis/ Fax: (206) 320-2626</p> <p align="center">limeel/ Email: ROI@swedish.org</p>	<p align="center">Swedish Medical Group</p> <p align="center">Taleefanka/ Phone: (206) 320-3025</p> <p align="center">Fakis/ Fax: (478) 238-9436</p> <p align="center">limeel/ Email: smgroi-wa@cioxhealth.com</p>
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Khidmadda waxa laga yaabaa inay la xidhiidho codsigaan.

Fees may be associated with this request.

Muhiim: Iswiidhishka iyo kuwa gacansaarka la leh mardambe ma daabacaan mana sii daayaan lambarada amniga bulshada ee bukaanka ilaa looga baahdo biil ahaan. Haseyeeshee, lambarada sooshiyaal sekuyuuritiga waxa laga yaabaa inay ku jiraan rikoorada bukaanka kuwaas jiray in ka badan sannado dhawra. Diiwaanada aad codsanaysid waxaa ku jira kara lambarkaaga amniga bulshada.

Important: Swedish and affiliates no longer print or release patient social security numbers unless required for billing. However, social security numbers may be included in patient records that are more than a few years old. The records you are requesting may include your social security number.

Xarunta, shaqaalaheeda, saraakiisha iyo dhakhaatiirtu waxa halkan laga cafinayaa mas'uuliyad ama xil kasta oo sharci ah ee shaacinta macluumaadka sare ilaa xadka la muujiyey ama lagu oggolaaday halkaan.



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Patient Identification Sticker

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Swedish Health Services iyo Xulufadeeda kuma sameeyaan takoor ku salaysan jinsiyad, midab, asal qaran, sinji, da' ama naafonimo barnaamijyada iyo hawlaha caafimaadka.

Swedish Health Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (Swedish Edmonds (888) 311-9178) (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 311-9127 (Swedish Edmonds (888) 311-9178) (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 (Swedish Edmonds (888) 311-9178) (TTY: 711).



**DALABKA BUKAANKA EE GELITAANKA DUWAANKA GAARKA AH
PATIENT REQUEST FOR ACCESS TO DESIGNATED RECORD SET (SOMALI)**

Magaca Bukaanka: _____ TAARIKHDA DHALASHADA: _____
 Patient's Name: _____ DOB: _____
 Magacyada Hore ee la Isticmaalay: _____ Taleefanka: _____
 Prior Name(s) Used: _____ Phone: _____
 Ciiwaanka Bukaanka: _____
 Patient's Address: _____
 Magaalada: _____ Gobolka: _____ Lambarka Zip: _____
 City: _____ State: _____ Zip Code: _____
 Iimeelka Bukaanka: _____
 Patient's Email: _____

Fadlan sii diiwaanadayda: Aniga cinwaanka kore leh ama helaha soo socda
 Please disclose my records to: Myself at the address above or the following recipient
 Magaca: _____ Cinwaanka: _____
 Name: _____ Address: _____
 Magaalada: _____ Gobolka: _____ Lambarka Zip: _____
 City: _____ State: _____ Zip Code: _____
 Taleefanka: _____ Fakis: _____ Iimeel: _____
 Phone: _____ Fax: _____ Email: _____

Fadlan ku soo dir diiwaanadayda adoo adeegsanaya:
 Please send my records via: MyChart Iimayl Cajalad Waraaqad Fakis
 MyChart Email Disc Paper Fax

**Waxaan codsanayaa warbixin ka timid adeegyada soo socda:
Anigoo ah am requesting information from the following facility(s):**

Liiska Isbitaalada ama Magaca Bixiyaha Bixiyaha	IYO / AMA	Liistada Rugaha Caafimaadka ama Magaca Bixiyaha
List Hospital(s) or Provider Name(s)	AND/OR	List Clinic(s) or Provider Name(s)

Inta udhaxeysa taariikhaha laga bilaabo: _____ ilaa: _____
 For the range of dates from: _____ to: _____



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SWEDISH

Patient Identification Sticker

Warbixinta lagoonayo in la bixiyo:

Information to be disclosed:

- | | |
|---|--|
| <input type="checkbox"/> Taariikhda & Eegida jidhka
History & Physical | <input type="checkbox"/> Soo koobida ka bixinta
Discharge Summary |
| <input type="checkbox"/> Warbixin Qalitaan:
Operative Report | <input type="checkbox"/> Waaxda Gurmadka
Emergency Department |
| <input type="checkbox"/> Warbixinta Cilad-baarista (shaybaarka,
raajada, EKG, iwm.)
Diagnostic Report (lab, x-ray, EKG, etc.) | <input type="checkbox"/> Warbixinta Qoraalada Horumarka
Report Progress Notes |
| <input type="checkbox"/> Kale (sheeg): _____
Other (specify): | <input type="checkbox"/> 2 sano ee lasoo dhaafay oo kaliya
Last 2 years only |

Khidmadda waxa laga yaabaa inay la xidhiidho codsigaan. Duwaanka qaar ayaa laga heli doonaa MyChart.
Fees may be associated with this request. Some records are unavailable to receive via MyChart.

Saxeexa Bukaanka: _____
(Foomka daabacan oo aad gacanta ku saxeeedo)

Taariikhda: _____

Patient Signature: _____
(Print form and sign by hand)

Date:

Magaca Wakiilka: _____
Representative Name:

Taariikhda: _____
Date:

Saxiixa Wakiilka: _____
Representative Signature:

Xiriirka Bukaanka:
Relation to Patient:

(Daabac foomka oo gacanta ku saxiix. Fadlan ku dar dukumiintiyada taageeraya.)
(Print form and sign by hand. Please include supporting documentation.)



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