SWEDISH

OGOLANSHAHA RASMIGA AH EE ISTICMAALIDA, IYO BIXINTA XOGTA CAAFIMAAD EE LA ILAALIYO
AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION (SOMALI)

Anigu Waxaan fahamsanahay waxa soo socda: I understand the following:

- **Waxaan xaq u leeyahay inaan diido inaan saxeexo foomkan si aan u oggolaado shaacinta ama fasixidda macluumaadkayga caafimaadka ee dhawrsan. Diidmada ah inaan saxeexo amar bixintaan wax saamayn ah kuma yeelan karto xaqa aan u leeyahay helida adeegyada daryeelka caafimaadka ama magdhawga adeegyada. Xaaladda kali ah ee diidmada inaan saxeexo amar bixintani ay saamayn ugu yeelan karto awoodayda helida adeegyada caafimaadku waa haddii adeegyada caafimadku ay yiihiin kuwo la xidhiidha cilmi baadhis ama ujeeddadoodu ay tahay oo kaliya inay siiyaan macluumaad caafimaad qof kale oo amar bixin looga baahan yahay si loo sameeyo shaac ka qaadidaas.**
  I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
- **Waxaa jiri kara lacag la xidhiidha codsigaan.**
  There may be a fee associated with this request.
- **Macluumaadka la isticmaalo ama la bixiyay iyadoo la raacayo oggolaanshahan waxa dhici karta mar kale in lasii bixiy karo iyada oo ka baxaysa xayndaabka ilaalinta sharciga fadaraalku. Si kastaba ha ahaatee, waxaan sidoo kale fahansanahay in sharciga federaalka ama sharciga gobolku uu xaddidi karo dib u bixinta xogta HIV/AIDS, macluuaadka caafimaadka maskaxda, warbixinta tijaabinta jinsiga, iyo baadhida daroogo/khamri, daawaynta, ama macluumaadka wareejinta.**
  Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.
- **Waxan xaq u leeyahay inaan helo nuqul ka mida amar bixintaan la saxeexay.**
  I have the right to receive a copy of this signed authorization.
- **Waxaan ku joojin karaa amar bixintaan qoraal mar walba. Haddii aan laga noqdo ogolaanshahayga, macluumaadka hoos lagu sharaxay looma sii isticmaali doono ama looma bixin doono ujeeddooyinka lagu sharaxay ogolaanshihii qoraalka ahaa. Waxa kali ah ee laga reebay waxa weeyi marka Swedishku ay qaadeen talaabo waafaqsan ogolaanshaha ama marka ogolaanshaha lagu heli xaalad caymis.**
  I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when Swedish has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

Fadlan u gudbi oggolaanshan ama ka noqoshadan mid kamid ah goobahan, iyadoo ku xidhan halka aad daryeelka ka heshay:
Please submit this authorization or revocation to one of these locations, depending on where you received care:

Swedish Medical Center	**Swedish Medical Group**
Release of Information Department 747 Broadway, Seattle, WA 98122 **Fakas**/Fax: (206) 320-2626 **Emeyl**/Email: ROI@swedish.org	**Taleefanka**/Phone: (206) 320-3025 **Fakas**/Fax: (478) 238-9436 **Emeyl**/Email: smgroi-wa@cioxhealth.com

Muhiim: Swedishku ma daabacdo ama ma bixiso lambarada sooshiyal sakyuuritiga ee bukaanka ilaa loogu baahado lacag-bixinta darteed. Si kastaba ha ahaatee, lambarada sooshiyal sekuyuuritiga waxaa kujiri kara macluumaadka bukaanka taas oo ah mudo dhawr sano ka hor ah. Macluumaadka aad ogolaanayso in labixiyo waxaa kujiri kara numbarkaaga sooshiyal sekuyuuritiga.
Important: Swedish no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

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Xarunta, shaqaalaheeda, saraakiisheeda iyo dhakhaatiirta halkan waxay u joogaan inay ka sii daayaan masuuliyad sharci oo kasta ama masuuliyadda bixinta macluumaadka xagga sare lagu faahfaahiyay iyo ogolaanshaha.
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, dalka lagasoo jeedo, sinji, da' ama laxaad la'aan 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.

FIIRO GAAR AH: Hadii aanad ku hadal Ingiriisi, waxa aad heleysaa adeegyada kaalmada luuqada oo bilaash ah. Lahadal (888) 311-9127 (TTY: 711).
ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (TTY: 711).

Waxaan u ogolaaday Swedishku inay isticmaalaan oo ay bixiyaan nuqulka warbixinta caafimaad ee gaarka ah ee hoos lagu qeexay ee la xidhiidha:
I authorize Swedish to use and disclose a copy of the specific health information described below regarding:

Magaca Bukaanka/Patient's Name:_____ **Taariikhda Dhalashada**/DOB: _____

Ciiwaanka Bukaanka/Patient's Address:_____ **Taleefanka**/Phone: _____

Magaalada/City: _____ **Gobolka**/State:_____ **Boosta**/Zip Code:_____

Waxa lasiin doonaa: To be disclosed to: ☐ **Iskeyga** Self **Ama Magaca Qaataha:** Or Recipient's Name:_____

Cinwaanka Helaha:_____
Recipient's Address:
Magaalada/City:_____ **Gobolka**/State:_____ **Boosta**/Zip Code:_____

Taleefanka/Phone:_____ **Fakaska**/Fax:_____ **Emeyl**/Email:_____

Fadlan ligu soo dira rikoorkayga iyadoo la ii soo marsiinayo: Please send my records via:
☐ **MyChart** MyChart ☐ **Emeyl** Email ☐ **Cajalad** Disc ☐ **Warqad** Paper ☐ **Fakas** Fax

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

Magaca Cusbitaalka (Liiska) & Taleefan Lambarka Hospital Name (List) & Phone Number	**Magaca Rugta caafimaadka (Liiska) & Taleefan Lambarka** Clinic Name (List) & Phone Number

Baaxadda taariikhaha laga bilaabo:_____ **ilaa:**_____
For the range of dates from: to:
Macluumaadka la xidhiidha baadhitaanada soo socda ama dhaawaca:_____
For information related to the following diagnosis or injury:

Warbixinta ladoonayo in la bixiyo/Information to be disclosed:

- ☐ **Taariikh & Jidhka**/History & Physical
- ☐ **Warbixinta Tafaasiisha Qalliinka**/Operative Report
- ☐ **Warbixinaha Baadhista Cudurka (shaybaadhka, raajada, EKG, iwm.)** Diagnostic Reports (lab, x-ray, EKG, etc.)
- ☐ **Guudmarka ka Bixista Cusbitaalka**/Discharge Summary
- ☐ **Warbixinta Waaxda Gurmadka**/Emergency Department Report
- ☐ **Qoraalada Kasoo Raynta**/Progress Notes
- ☐ **Wax kale (sheeg)**/ Other (specify):_____

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U jeeddada oo ah:_____
For the purpose of:

Iyada oo laga noqdo moojee, ogolaanshahani waxa uu ku eeg yahay 180 maalmood kadib ama taariikhdan:_____
Unless revoked, this authorization expires in 180 days or on this Date:

Shuruudaha: Ogolaanshahani, haddii aanan anigu sicad ugu xadidin qoraal, waxay quseyn doontaa dhamaan noocyada tijaabinta iyo/ ama daawaynta xanuunada lagu kala qaado galmada, AIDS, xanuunka HIV, khamrida iyo/ ama isticmaalka daroogada, xaaladaha caafimaad ee maskaxada ama warbixinada kale ee xasaasiga ah.

Terms: This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

Saxeexa Bukaanka: _____ **Taariikhda/**Date:_____
Patient Signature: **(Foomka daabacan oo aad gacanta ku saxeexdo)**
(Print form and sign by hand)

Magaca Wakiilka Bukaanka: _____ **Taariikhda/**Date:_____
Patient Representative Name:

Magaca Wakiilka Bukaanka: _____
Patient Representative Signature: **(Foomka daabcan oo aad gacanta ku saxeexay. Fadlan waxa aad ku dartaa waraaqaha taageerada.)**
(Print form and sign by hand. Please include supporting documentation.)

Xidhiidhka uu la leelayahay bukaanka:_____
Relation to Patient:

1ROI