Complete and print.

Reset Form

MAYO CLINIC

Oggolaanshaha in Loo shaaciyo Macluumaadka Ilaashan ee caafimaadka Kooxda saddexaad

Authorization to Release Protected Health Information to a Third Party (Somali)

TO BE SCANNED

Form content retained in medical record.
Route to HIMS Scanning.

Tilmaamaha: Foomkan waxaa isticmaalaya bukaanka ama wakiilka sharciga ah si uu u oggolaado u shaacinta macluumaadka kooxda saddexaad (aan ahayn xubinta qoyska ama saaxiib) sida shirkada caymiska, loo shaqeeyaha, ama ujeedooyinka sharciga ah, iwm. U daabac si cad, qayb kastaa waxay u baahan tahay in la buuxiyo si ay ansax u ahaato.

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Print clearly; each section needs to be completed to be valid.

1. *(buuxi qaybaha diiwaan-gelinta, ama ku dhaji halkan warqadda aqoonsiga bukaanka)*
(complete fields or place patient label here)

Magaca Bukaanka *(Kan Koowaad, Kan Dhexe, Kan dambe)*
Patient Name *(First, Middle, Last)*

Taariikhda Dhalashada *(bisha-maalinta-sanadka)*
Birth Date *(mm-dd-yyyy)*

Lambarka qolka *(haddii ay habboontahay)*
Room Number (if applicable)

Lambarka Mayo Clinic
Mayo Clinic Number

Shaqaalaha uunbaa isticmaali kara / Staff Use Only

☐ ROI to Send Records ☐ Scan to Chart

☐ Information Released by LAN ID | Date *(mm-dd-yyyy)*

2. Macluumaadka Bukaanka Dheeraadka ah / Additional Patient Information

Magaca Hore ama Asalka ah (haddii ay habboon tahay) *(Koowaad, Dhexe, U dambeeya)*
Previous or Maiden Name (if applies) *(First, Middle, Last)*

Telefoonka Wakhtiga Maalinta
Daytime Phone

☐ Sax santuuqan haddii uu bukaanku dhintay
Check this box if patient is deceased.

Cinwaanka Bukaanka *(Jidka, Magaalada, Gobolka, Lambarka Sibka)*
Patient Address *(Street, City, State, ZIP Code)*

3. Ujeedada Shaacinta / Release Purpose

Sax boqoska haboon ama qor ujeedo kale. / Check appropriate box or write in other purpose.

☐ Sii wadista daryeelka / Continuing care ☐ Naafanimada / Disability ☐ Buuxinta foomamka / Forms completion ☐ Caymiska / Insurance
☐ Magdhowga / Legal ☐ Sharciga ah ee shaqaalaha / Workers' compensation
☐ Kale, magacow / Other, specify _____

4. Shaacinta Macluumaadka KA SOCOTA
Release Information FROM

Sax hal santuuq oo buuxi haddii ay habboon tahay.
Check one box and complete if applicable.

☐ **Mayo Clinic**
Waxaa ka mid ah dhammaan Mayo Clinic iyo goobaha Nidaamka Caafimaadka Mayo Clinic / Includes all Mayo Clinic and Mayo Clinic Health System locations

☐ **Kale,** magacow ururka, waaxda, ama shakhsiga (buuxi layn kasta oo hoose) / **Other,** specify organization, department, or individual (complete each line below)

_____

Jidka / Street _____

Magaalada / City _____

Gobolka / State _____ Lambarka Sibka / ZIP Code _____

Telefoonka / Phone _____

Fax _____

5. Shaaci/ U dir macluumaadka ILAA
Release/Send Information TO

Sax hal santuuq oo buuxi haddii ay habboon tahay.
Check one box and complete if applicable.

☐ **Mayo Clinic**

Waaxda. / Dept. _____

Ku. / Attn. _____

Fagas / Fax _____

☐ **Kale,** magacow ururka, waaxda, ama shakhsiga (buuxi layn kasta oo hoose) / **Other,** specify organization, department, or individual (complete each line below)

_____

Jidka / Street _____

Magaalada / City _____

Gobolka / State _____ Lambarka Sibka / ZIP Code _____

Telefoonka / Phone _____

Fax _____

Oggolaanshan waxa uu dhacayaa 1 sano laga bilaabo taariikhda saxeexa *iyaddoo taariikh kale la magacowyo mooyaane:*

_____

This authorization will expire in 1 year from date of signature *unless another date is specified:*

☐ **Sixidda santuuqan** Waxaan oggolaanayaa is dhaafsiga joogtada ah ee macluumaadka u dhaxeeya kooxaha sare ilaa oggolaanshaha muddadiisu dhacdo ama laga noqodo.
By checking this box I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ **Sixidda santuuqan** Sidoo kale waxaan oggolaanayaa shaacinta diiwaanada ee booqashooyinka mustaqbalka ama joogitaanada ka dib taariikhda saxeexaysa ilaa oggolaanshahan muddadiisu dhacdo ama laga noqdo.
By checking this box I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

Oggolaanshaha in Loo shaaciyo Macluumaadka Ilaashan ee caafimaadka Kooxda saddexaad (sii socota)

Authorization to Release Protected Health Information to a Third Party (Somali) (continued)

(buuxi qaybaha diiwaan-gelinta, ama ku dhaji halkan warqadda aqoonsiga bukaanka)
(complete fields or place patient label here)

Magaca Bukaanka *(Kan Koowaad, Kan Dhexe, Kan dambe)* Patient Name *(First, Middle, Last)*
Taariikhda Dhalashada *(bisha-maalinta-sanadka)* Birth Date *(mm-dd-yyyy)*
Lambarka Mayo Clinic Mayo Clinic Number

6. Macluumaadka Dirista / Delivery of Information

Qaabka La doorbidayo / Preferred Method

- ☐ Nuqulka qoran (waxaa ku jiri kara foomamka la buuxiyay)
  Written copy (may include completed forms)
- ☐ Hadal keliya / Verbal only

Taariikhda Macluumaadka Loo baahan yahay *(mm-dd-yyyy)*
Date Information Needed by *(mm-dd-yyyy)*

Macluumaadka qoran waxaa boostadda loogu soo diri doonaa iyaddoo qaabka kale la eego mooyaane.

- ☐ Bogga madasha Bukaanka – Mayo Clinic Adeegyada Onlaynka ah ee Bukaanka / Patient Portal – Mayo Clinic Patient Online Services
- ☐ Fagas (tirada sare ku qoran tahay qaybtan 5) / Fax (number listed above in section 5)
- ☐ Cinwaanka iimaylka / Email address _____
- ☐ Soo qaadista goobta xaga Mayo Clinic, magacow / Pick-up at a Mayo Clinic location, specify _____
- ☐ CD/DVD
- ☐ USB flash/thumb drive
- ☐ Kale (magacow) / Other, specify _____

7. Diiwaanada ama Warbixinaha La shaacinayo / Records or Reports to Be Released

Haykalka Wakhtiga La shaacinayo / Timeframe to Be Released

Taariikhda(ha) / Date(s) _____ *(mm-dd-yyyy)* ama Sanadka(aha)a / or Year(s) _____ *(yyyy)*

Dhokumentiga/Qoraalka(da) (sax dhammaan inta habboon) / **Document/Note(s)** (check all that apply)

- ☐ Dhaqanka caafimaadka/Maskaxda/Qoraalada nafsiyeed / Behavioral health/Mental/Psychological notes
- ☐ Waaxda gurmadka/qoraalada daryeelka degdega ah / Emergency department/Urgent care notes
- ☐ Qoraalada Qalintaanka/Qaliinada / Operative/Procedure notes
- ☐ Qoraalada Adeeg bixiyaha / Provider notes
- ☐ Qoraalada daawayneed (jidhka, daawaynta jidheed, haddalka) / Therapy notes (physical, occupational, speech)
- ☐ Kale, magacow / Other, specify _____

Waxaan fahmay macluumaadka la shaacinayo inuu ku jiri karo dhaqanka iyo/ama daryeelka caafimaadka maskaxda, iyo natiijooyinka baadhitaanka HIV. / I understand the information to be released may include behavior and/or mental health care, and HIV test results.

Diiwaanada Dheeraadka ah (sax dhammaan inta haboon) / **Additional Records** (check all that apply)

- ☐ Liiska xasaasiyada / Allergy list
- ☐ Tallaalada / Immunizations
- ☐ Liiska dawooyinka / Medication list
- ☐ Macluumaadka biil bixinta diiwaanada la bixiyay / Billing information for records checked
- ☐ Natiijooyinka shaybaadhka / Laboratory results
- ☐ Natiijooyinka Baadhitaanka shaybaadhka ee HIV / HIV lab test results
- ☐ Baadhitaanka hida sidaha / Genetic testing
- ☐ Warbixinta(ha) xaaladaha cudurka / Pathology report(s)
- ☐ EKG(s)/Cardio/Echo / EKG(s)/Cardio/Echo
- ☐ Warbixinta(ha) raajada / Radiology report(s)
- ☐ Sawirada raajada, magacow baadhida(taanada) qaybta(ha) jidhka
  Radiology image(s), specify exam(s)/body part(s)

Isticmaalka Walxaha Mukhaadaraadka iyo Qabatinka Maandooriyaha (sax dhammaan inta ku habboon)
Substance Abuse and Addiction Treatment Records (check all that apply)

- ☐ Qiimaynta/Qiimaynaha / Assessment/Evaluation
- ☐ Taarikhda iyo Baadhitaanka jidhka / History and physical exam
- ☐ Qoraalada qaybaha badan / Multidisciplinary notes
- ☐ Marti qaadka ka qayb galka waalidka / Family participation invitation
- ☐ Su'aalaha xog qaadista / Questionnaires
- ☐ Daawaynta/Ka saarida cusbitaalka oo kooban / Treatment/Discharge summary
- ☐ Qorshayaasha daawaynta / Treatment plans
- ☐ Kale, magacow / Other, specify _____

Kale, Magacow haddii ay habboon tahay / **Other,** specify if applicable _____

Oggolaanshaha in Loo shaaciyo Macluumaadka Ilaashan ee caafimaadka Kooxda saddexaad (sii socota)

Authorization to Release Protected Health Information to a Third Party (Somali) (continued)

(buuxi qaybaha diiwaan-gelinta, ama ku dhaji halkan warqadda aqoonsiga bukaanka)
(complete fields or place patient label here)

Magaca Bukaanka *(Kan Koowaad, Kan Dhexe, Kan dambe)* Patient Name *(First, Middle, Last)*
Taariikhda Dhalashada *(bisha-maalinta-sanadka)* Birth Date *(mm-dd-yyyy)*
Lambarka Mayo Clinic Mayo Clinic Number

8. Saxeexa iyo Taariikhda Bukaanka ama wakiilka sharciga ah waa inay saxeexaan oo taariikhda ku qoraan oggolaanshahan.

- Oggolaanshahan waxaa laga noqon karaa wakhti kasta iyaddoo la siinayo ogaysiiska qoran ee dib uga noqoshada Macluumaadka Caafimaadka Adeegyada Maamulka (HIMS) Shaacinta Macluumaadka (ROI) waaxda xaga xarunta shaacinta macluumaadka, laga reebo ilaa xadka Adeeg bixiyayaashu ay hadda ka hor uga qaadeen tallaabo iyaddoo la isku halaynayo.
- Waxaan fahmay in macluumaadka la isticmaalay ama la shaacaiyay ee waafaqsan oggolaanshahan dib ayuu u shaacin karaa qofka hela oo aanay in dheeraad ah ilaalin karin gobolka ama Shuruucda Gaar ahaanshaha Federaalku (42 CFR Part 2) (HIPAA).
- Waxaan fahmayaa in Mayo Clinic aanay shuruud ku xidhi doonin daawaynta haddii aan saxeexo oggolaanshahan.
- Waxaan u baahan karaa nuqulka oggolaanshaha saxeexan.
- Waxaa laga iiga qaadi karaa kharashka nuqulka warqaddaha la koobiyeeyay sida waafaqsan sharciga gobolka.
- Waxaan leeyahay xaqa aan ku baadho oo ku helo nuqulka qoraalka la shaacinayo.

Fiiro: Bukaanka (18 sanadood ama ka wayn) waa inuu oggolaadaa shaacinta macluumaadkooda iyaddoo bukaanku uu naafo yahay ama dhintay mooyaane. Haddii loo saxeexayo bukaanka yar, halkan waxaan ku sheegayaa in xuquuqdayda waalideed aanay igala noqon maxkamadda sharcigu. Xaalada(ha) gaarka ah ayaa u baahan kara oggolaanshaha ilmaha yar.

8. Signature and Date The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department at the facility releasing the information, except to the extent that the Providers have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I understand that Mayo Clinic will not condition treatment on whether I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Saxeexa (loo baahday) **Signature** (required) ▶ Signature Required	**Taariikhda** (loo baahday) *(mm-dd-yyyy)* **Date** (required) *(mm-dd-yyyy)*

Magaca Daabacan ee Qofka saxeexaya **(haddii aanu bukaanka ahayn)** *(Koowaad, Dhexe, U dambeeya)*
Printed Name of Person Signing **(if not patient)** *(First, Middle, Last)*

Xidhiidhka haddii aanu Ahayn Bukaanka (warqaddaha sharciga ee xaqa helida ee qofka saxeexaya looga baahan karo)
Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

☐ Waalidka / Parent ☐ Waalidka labbaad / Stepparent ☐ Masuulka sharciga ah / Legal guardian
☐ Waalidka Korsashada / Foster parent ☐ Awooda daryeelka caafimaadka ee qareenka/wakaiilka / Health care power of attorney/agent
☐ Kale / Other _____

HIMS* ShaacintaMacluumaadka xidhiidhka / HIMS* Release of Information Contact Information

Arizona	**Florida**	**Rochester**	**MCHS MN**	**MCHS WI**
13400 East Shea Boulevard Scottsdale, AZ 85259	4500 San Pablo Road Jacksonville, FL 32224	200 First Street SW Rochester, MN 55905	1025 Marsh Street Mankato, MN 56001	1400 Bellinger Street Eau Claire, WI 54703-5211
Telefoonka / Phone 480-301-4211	Telefoonka / Phone 904-953-2022	Telefoonka / Phone 507-284-4594	Telefoonka / Phone 507-594-2621	Telefoonka / Phone 715-838-6395
Fagaska / Fax 480-301-7282	Fagaska / Fax 904-953-2242	Fagaska / Fax 507-284-0161	Fagaska / Fax 507-422-0902	Fagaska / Fax 715-838-3058

Xusuusin: Haddii loo diraayo diiwaano**ILAA** Mayo Clinic, diiwaanada fagaska ila alambarka la sheegay ee qaybta 5 ee bogga 1.
Reminder: If sending records **TO** Mayo Clinic, fax records to number indicated in section 5 on page 1.

*Macluumaadka Caafimaadka Maamulka Adeegyada
*Health Information Management Services

Print

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