Community Health Centers

OLAANSHAHA DIRISTA MACLUUMAADKA CAAFIMAADKA

Kaafis Ugu Dir Duwaanka Caafimaadka: (802) 860-4313
Iimeel Ugu dir Duwaanka Caafimaadka Ilkaha: dentalxrays@chcb.org

Foomkan waxa uu u ogolaadaa CHC inay si af ah ula xidhiidho ruuxa awooda loo siiyay ama hay'ad ku qoran hoos.

Magaca Bukaanka: ____________________________________ Taariikhda dhalashada: ____________________

Cinwaanka: ____ Taleefanka: __________________________

Sababta Bixinta: Fadlan dooro sababta bixinta macluumaadkaaga:

☐ Isku duwida daryeelka
☐ Wareejinta daryeelka
☐ Ujeedooyinka sharciga
☐ Nuqulka bukaanka
☐ Ikhtiyaar labaad
☐ Waxkale (fadlan sharax):

Fadlan dooro dhamaan macluumaad aad doonayso in la wadaago:

Caafimaad:
☐ BUUXI DUWAANKA CAAFIMAADKA - **Waxaa kamid ah duwaanada caafimaadka ee hore ee hay'adaha banaanka ee CMC ugu jira faylka.**
Taariikhda inta ay u dhaxayso: ___/___/____ ilaa ___/___/_____ **Hadii aan la sheegin taariikh gaar ah, dhamaan duwaanada noocan ah ee la doortay waa la wadaagi doonaa.**
☐ Waxkale (natiijooyinka shaybaadhka, balamaha, macluumaadka kharash dalicida, iwm. Fadlan sharax):

Caawimaada Maskaxda/Dhimirka:
☐ Buuxi Duwaanka Dabiibka Caafimaadka Maskaxda/Dhimirka
Taariikhda inta ay u dhaxayso: ___/___/____ ilaa ___/___/_____ **Hadii aan la sheegin taariikh gaar ah, dhamaan duwaanada noocan ah ee la doortay waa la wadaagi doonaa.**
☐Waxkale(fadlan sharax):

Daryeelka ilkaha:
☐ Raajiga ilkaha – Dhamaan
☐Waxkale(fadlan sharax):

Macluumaadka LAGA DALBADAY: ____

Cinwaanka:
____

Taleefanka: ______________________________ Faakis: _________________________

Macluumaadka WAXAA LA SIINAYAA: ____

Cinwaanka: ____

Taleefanka: ______________________________ Faakis: _________________________

Taariikhda ama dhacdada ogolaanshahan uu ku eeg yahay: ____

Waxa aan fahansanahay in hadii aanan sheegin taariikhda kore ee ay ku eeg tahay, markaa ogolaanshahan inuu ku eeg yahay hal sano oo ka bilaabma taariikhda ugu danbaysa ee adeegyada ay i siiso CHC. **Waxa aan fahansanahay in macluumaadka la bixiyay ay kamid noqon karaan duwaanada caafimaadka, dhimirka, caafimaadka maskaxda iyo.ama balwadaha mukhaadaraadka iyo khamrida.** Waxa aan fahansanahay in Duwaankayga Caafimaadka uu ilaaliyay Sharciga La Xisaabtanka iyo Caymiska Caafimaadka Wareega 1996 ("HIPAA"), 45 Qaybaha 160 iyo 164, oo lama bixin karo iyada oo aan la haynin ogolaanshahayga qoraalka ah iyada oo sida kale ay u dhigayaan moojee qawaaniinta gobolka iyo federalku. Koobiga ama nuqulka ogolaanshahani waxa uu lamid yahay sida ka rasmiga ah. Waxa aan fahansanahay in la ii diidi karo adeegyada hadii aan diido in aan ogolaado u bixinta wixii ujeedo daawayn, lacag ama shaqada daryeelka caafimaad ah. La iima diidi doona adeegyada hadii aan diido in aan ogolaado u bixinta wixii ujeedo kale ah. Waxa aad u ogolaanaysaa Xarumaha Caafimaadka Bulshada ee Burlington inay bixiyaan duwaanadaada iyada oo ah qaababaka soo socda: af, qoraal, elektoroonig, iyada oo sida kale loogu sheego moojee halkan.

READ ONLY

Saxeexa Bukaanka: ____ Taariikhda: _____________________

Saxeexa Waalidka, Koriyaha, ama Wakiilka Sharciga ah: ________________________________ Taariikhda: _____________________

Sharaxa awooda saxeexa bukaanka cida matalaysa: ___________________________ Lambarka xidhiidhka: _____________________

Waxa aan fahmay in aan ka noqon karo ogolaanshahan wakhti kasta. Go'aankayga ka noqoshada ogolaanshahan ma saamayn doono duwaanada hore loogu bixiyay ogolaanshahan. Waxa aan halkan kaga noqonayaan ogolaanshaha: ______________ (taariikhda). Haku bixinina wax kale oo macluumaad ah ogolaanshahan:
Saxeexa: ____

Dib u eegid lagu sameeyay Noofember 2023

READ ONLY

AUTHORIZATION TO SEND HEALTH INFORMATION

Fax Medical Records to: (802) 860-4313 Email Dental Records to: dentalxrays@chcb.org

This form allows CHC to verbally communicate with the authorized person or organization listed below.

Patient Name: ____ Date of birth: ____________________

Address: ____ Phone: ________________________

Reason for Release: Please choose the reason(s) for the release of your information:

☐ Coordination of care
☐ Transfer care
☐ Legal purposes
☐ Patient copy
☐ Second opinion
☐ Other (please describe):

Please choose all information you would like to have shared:

Medical:

☐ COMPLETE HEALTH RECORD - **This includes past medical records from outside agencies that CHC has on file.**

Date range: ___/___/____ to ___/___/_____ **If no dates are specified, all records of this type selected will be shared.**

☐ Other (test results, appointments, billing information, etc. Please describe):

Mental Health/Psychiatry:

☐ Complete Mental Health Therapy/Psychiatric Record

Date range: ___/___/____ to ___/___/_____ **If no dates are specified, all records of this type selected will be shared.**

☐ Other (please describe):

Dental:

☐ Dental x-rays – All
☐ Other (please describe):

Information REQUESTED FROM: ____

Address: ____

Phone: ____________________________ Fax: _______________________

Information RELEASED TO: ____

Address: ____

Phone: ____________________________ Fax: _______________________

Date or event upon which this consent will expire: ____

I understand that if I do not state a date of expiration above, then this consent will expire one year from the last date of service to me at CHC**. I understand that information released may include medical, psychiatric, mental health and/or drug and alcohol records.** I understand that my Medical Records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by state and federal regulations. A photocopy or facsimile of this consent is valid as is the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. You are authorizing the Community Health Centers of Burlington to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here.

Patient Signature: ____ Date: ____________________

Parent, Guardian, or Legal Representative Signature: ______________________________ Date: ____________________

Describe authority to sign on behalf of patient: ______________________________ Contact number: __________________

I understand that I may revoke this consent at any time. My decision to revoke this consent will not affect the records that were previously released under this consent. I hereby revoke this consent on: _____________ (date). Do not release any further information under this consent.
Signature: ____

Revised November 2023