Community Health Centers

IDHINI YA KUTUMA TAARIFA ZA AFYA

Tuma Faksi ya Taarifa za Matibabu kwenda: (802) 860-4313
Tuma Barua Pepe ya Taarifa za Meno kwenda: dentalxrays@chcb.org
Fomu hii inatoa ruhusa kwa CHC kuwasiliana na mtu aliyeidhinishwa au shirika lililoorodheshwa hapo chini.

Jina la Mgonjwa: _____ Tarehe ya kuzaliwa: _____

Anwani: _____ Simu: _____

Sababu ya Kutoa: Tafadhali chagua sababu ya kutoa taarifa zako za afya:

☐Uratibu wa uangalizi
☐Kuhakikisha uangalizi
☐Madhumuni ya kisheria
☐Nakala ya mgonjwa
☐Maoni ya pili
☐Nyingine (tafadhali bainisha):

Tafadhali chagua taarifa zote ambazo ungependa zitolewe:

Matibabu:

☐ TAARIFA KAMILI YA AFYA - **Hii inajumuisha taarifa za zamani za matibabu kutoka mashirika ya nje ambayo yapo kwenye faili la CHC.**
Tarehe kuanzia: ___/___/____ hadi ___/___/_____ **Kama hakuna tarehe iliyobainishwa, taarifa zote za aina hii zilizochaguliwa zitatolewa.**
☐ Nyingine (majibu ya vipimo, miadi, taarifa za bili, nk. Tafadhali bainisha):

Afya ya Akili/Magonjwa ya Akili:

☐ Taarifa Kamili ya Matibabu ya Afya ya Akili/magonjwa ya Akili
Tarehe kuanzia: ___/___/____ hadi ___/___/_____ **Kama hakuna tarehe iliyobainishwa, taarifa zote za aina hii zilizochaguliwa zitatolewa.**
☐Nyingine (tafadhali bainisha):

Meno:

☐ X-ray ya meno – Zote
☐Nyingine (tafadhali bainisha):

Taarifa IMEOMBWA KUTOKA: _____

Anwani: _____

Simu: _____ Faksi: _____

Taarifa IMETOLEWA KWA: _____

Anwani: _____

Simu: _____ Faksi: _____

Tarehe au tukio ambalo kwayo idhini hii itafikia tamati: _____

Ninaelewa kwamba kama sitataja tarehe ya mwisho wa matumizi hapo juu, basi idhini hii itatamatika mwaka mmoja kutoka tarehe ya mwisho ya kuhudumiwa na CHC**. Ninaelewa kwamba taarifa zilizotolewa zinaweza kujumuisha taarifa za matibabu, magonjwa ya akili, afya ya akili na/au dawa na pombe.** Ninaelewa kwamba Taarifa zangu za Matibabu zinalindwa kwa mujibu wa Sheria ya Ubebekaji na Uwajibikaji wa Bima ya Afya ya 1996 ("HIPAA"), 45 Sehemu ya 160 na 164, na haziwezi kutolewa bila idhini yangu ya maandishi isipokuwa kama imeelezwa vinginevyo na kanuni za jimbo na serikali kuu. Nakala au faksi ya idhini hii ni halali kama ilivyo halisi. Ninaelewa kwamba ninaweza kunyimwa huduma nikikataa kuidhinisha utoaji wa taarifa kwa madhumuni ya matibabu, malipo au shughuli za huduma za afya. Sitanyimwa huduma nikikataa kuidhinisha utoaji taarifa kwa madhumuni mengine. Unaidhinisha Vituo vya Afya vya Jamii vya Burlington (Community Health Centers of Burlington) kutoa taarifa zako katika miundo ifuatayo: kwa mdomo, maandishi, kielektroniki, isipokuwa kama imebainishwa vinginevyo hapa.

Sahihi ya Mgonjwa: _____ Tarehe: _____

Sahihi ya Mzazi, Mlezi, au Mwakilishi wa Kisheria: _____ Tarehe: _____

Eleza mamlaka ya kutia sahihi kwa niaba ya mgonjwa: _____ Namaba ya simu: _____

Ninaelewa kwamba ninaweza kuondoa idhini hii wakati wowote. Uamuzi wangu wa kuondoa idhini hii hautaathiri taarifa ambazo zilitolewa awali kwa idhini hii. Ninaondoa idhini hii tarehe: _____ (tarehe). Usitoe taarifa zingine zozote kwa idhini hii.
Sahihi: _____

Imepitiwa Novemba 2023

Community Health Centers

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: _____