Improving health. Improving lives.

DAIM NTAWV TSO CAI KEV SIB THAM LUS

Tus neeg mob Npe	MRN#	Hnub Yug	Xov Tooj
______________	______________	______________	______________

COV NTAUB NTAWV UAS YUAV NTHUAV TAWM: Tham lus nkaus xwb-tsis muaj ntaub ntawv theej txog muab

KEV THAM NROG NRUAB NRAB TXOG:

______________________________ **thiab** Npe: ______________________________
(Lub npe haus maum, tus kws kho mob/cov neeg uas haujlwm) (ib tug neeg ib daim ntawv)

THIAB/LOSIS

KAWS LUS CIA RAU NTAWM TUS XOV TOOJ (nrog rau txhua yam lus kaw cia tshwj tias yog tau hais tseg hauv qab) ____________________

Tseg tej yam lus kaw cia rau:____

LUB NTSIAB NTAWM KEV THAM LUS: Tauj kev saib xyuas tshwj tias yog hais ncaj nrais no: ________________________________

DAIM NTAWV HNUB KAWG

☐ Tsis muaj hnub Kawg ☐ Kawg rau hnub ______________________________

KOJ TXOJ CAI HAIS TXOG NTAWM KEV TSO CAI

Txoj cai kuaj losis txais ib daim ntawv theej hais txog ntawm cov ntaub ntawv uas yuav siv losis nthuav tawm: Kuv nkag siab tias kuv yeej muaj txoj cai kuaj losis txais ib daim ntawv uas theej qhia txog ntawm cov ntaub ntawv uas yuav raug siv losis nthuav tawm.

Txoj cai tau txais ib daim ntawv uas luam txog ntawm kev tso cai: Kuv nkag siab tias yog kuv txaus siab kos npe rau daim ntawv tso cai no, uas kuv tsis thaj ua los tau, kuv thov luam ib daim uas kuv tau kos npe rau kuv los tau.

Txoj cai tsis lees kos npe rau kev tso cai: Kuv nkag siab tias kuv tsis muaj feem dabtsi uas yuav tau kos npe rau daim ntawv no thiab tus neeg/losis koom haum uas muaj npe li sauv uas kuv tso cai siv thiab/losis nthuav tawm kuv cov ntaub ntawv txwv tsis tau kev kho mob, them, kev nkag rau ib qhov health plan losis kev tsim nyog tau txais kev pab cuam rau kev kuaj mob los ntawm kuv txoj kev txiav txim uas kos npe rau daim ntawv tso cai no.

Txoj cai uas thim daim ntawv tso cai: Kuv nkag siab tias kuv yuav tau ua ib daim ntawv ceeb toom uas thiaj li tsim nyog tshem tawm daim ntawv tso cai no. Kom tau cov ntaub ntawv qhia txog yuav ua li cas thiaj li thim tau kuv kev tso cai no losis tau txais ib daim theej ntawm kuv kev thim, kuv tiv tauj tau rau Access Community Health Centers. Kuv yeej pom tau tias kuv kev thim nws yuav tsis ua haujlwm rau yam twb siv tag los losis nthuav tawm hais txog ntawm kuv tej ntaub ntawv kuaj mob uas tus neeg losis lub koom hoom uas kuv tau sauv tseg rau sauv uas twb tau kuv kev tso cai duas los lawm. Access Community Health Centers yuav txwv tsis tau kev kho tom qab uas kuv ua tag daim ntawv tso cai no. Kuv nkag siab tias cov ntaub ntawv uas tau siv losis nthuav tawm raws li daim ntawv tso cai no kuj yuav tau rov qab nthuav tawm dua los ntawm tus tau txais.

Nthuav tawm txaus ntxiv: Kuv nkag siab tias, yog tus neeg losis lub koom haum uas kuv tso cai txais thiab/losis siv tej ntaub ntawv kuaj mob ua tau tiv thaiv yuav tsis muab los tswj rau tseem fwv txoj cai tsis pub qhia tawm ntaub ntawv kuaj mob, lawv kuj muab cov ntaub ntawv kuaj mob uas tau kev tiv thaiv rov qab muab los nthuav tawm thiab kuj yuav tsis tau kev tiv thaiv los ntawm tseem fwv txoj cai tsis pub qhia tawm ntaub ntawv kuaj mob. Kuv nkag siab tias cov ntaub ntawv no tso tawm electronically los kuj tau.

Kom ua raws li cov lus uas tau hais sauv, kuv tso cai siv thiab/losis nthuav tawm kuv tej ntauv ntawv kuaj mob. Kuv kev kos npe kuj tso cai tso tawm kuv cov ntaub ntawv uas txheeb txog AIDS/HIV, kev saib xyuas thiab kho kev nyuaj siab, kev siv cawv losis tshuaj yeeb thiab kev xiam oob qhab, tab sis tsuas tseg yam tom ntev no:______________________________

Tus neeg mob losis Tus sawv cev raw cai kos npe/ Txheeb	Hnub Kos Npe
______________________________	______________________________

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hurau 1-608-443-5480 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-443-5480 (TTY: 711).

Improving health. Improving lives.

AUTHORZATION FOR VERBAL COMMUNICATION

_____________________________ __________________ __________________ ______________________

Patient Name MRN # Date of Birth Phone

INFORMATION TO BE DISCLOSED: Verbal communication only – no copies of records provided

COMMUNICATION BETWEEN:

____ **and** Name: ____
(list name of healthcare facility, specific health care provider/staff member) (only one person/entity per form)

AND /OR

Leave Voice Mail at the Following Phone Number (includes all types of voice mails unless limited below):

____

Limit types of voicemail to: ____

PURPOSE OF COMMUNICATION: Continued Care unless specified: _______________________________________

THIS AUTHORIZATION WILL EXPIRE in one year from signature unless otherwise indicated below:

☐ Indefinite ☐ Ends on (date) _______________________________________

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Access Community Health Centers. I am aware with my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. Access Community Health Centers will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that this information may be released electronically.

Expiration Date: This authorization is effective for one (1) year from the date signed unless otherwise indicated. → ____________________
Date

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. My signature also authorizes the release of information related to AIDS/HIV, mental health care and treatment, alcohol or drug use and developmental disabilities, except for the following exception: ____

____ ____

Patient or Legal Representative Signature / Relationship Date of Signature

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hurau 1-608-443-5480 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-443-5480 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hurau 1-608-443-5480 (TTY: 711).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-443-5480 (TTY: 711).