Hmong

Authorization for Release of Private Health Information

Ntawv Tso Cai Tso Lus Kom Qhib Cov Ntawv Hais Txog Tus Kheej Kev Noj Qab Haus Huv

Patient/*Tus Tub Mob*:

Name/*Luv npe** _____ **Birth Date/*Hnub yug**** _____

Address/*Chaw nyob* * _____ **City/*Zos* *** _____

State/*Xeev* * _____ **Zip Code/*Leb* *** _____

Date of Injury/*Hnub raug mob** _____ **Date(s) of Treatment/*(Cov) Hnub mus kuaj mob**** _____

Information to be Released to/*Tso Cai Qhib Cov Ntawv Rau:*

☐ **City of Minneapolis**

ATTN: _____

350 S. 5th Street, Room _____ **Phone:** _____

Minneapolis, MN 55415 **Fax:** _____

or

☐ **City of Minneapolis**

ATTN: _____

Addr: _____

Minneapolis, MN _____

Phone: _____ **Fax:** _____

Custodian of Records/Qhov Chaw Tuav Ntaub Ntawv*:*

Hospital/Doctor * _____

Tsev Kho Mob/ Chaw kuaj mob/ Thaj maum

Address/*Chaw nyob* _____ **Telephone/*Xov Tooj*** _____

Information to be Released:

All ☑ certified / ☑ uncertified

Medical records pertaining to the above-referenced incident date treatment date(s), including but not limited to:

☑ x-ray/radiology reports ☑ photographs

☑ discharge summary ☑ operative reports

☑ ER reports ☑ consultation reports ☑ other

Con Ntawv Tso Cai Qhib Yog:

Tag nhro ☑ cov ntawv kuaj mob qhia tau tias muaj tiag losyog/ ☑ cov ntawv kuaj mob ua qhia tsis tau tias muaj tseeb hais txog lub sib hawm muaj nyob rau daim ntawv nos thiab cov hnub tau mus kuaj mob, raws li cov nram no tabsis tsis yog tag rau qhov muaj nos xwb:

☑ *duab fais fab/tus thaij fais fab cov ntawv sau* ☑ *duab*

☑ *ntawv sau ua ntej tso tawm haus maum* ☑ *ntawv sau txog kev phais*

☑ *chav kuaj mob kub ceev(ER) cov ntawv sau* ☑ *ntawv sau txog kev sab laj*

☑ *lwm yam ntawv*

Purpose: This information is needed for the following Purpose: Use in the investigation and prosecution of the case(s):

Lub Ntsiab Xav Tau: Cov ntaub ntawv coj los siv raws li muaj nos:Coj los xwj thiab txiav ntxim rau rooj plaub (cov plaub):

State of Minnesota v/*Lub Xeev Minnesota xub* _____

Case Number(s) /*Rooj Plaub tus zauv(s)* _____

1. This authorization will automatically expire one year from the date of my signature.
2. This authorization may be revoked by written request of the patient at any time to the address listed for the requesting entity. A revocation will not apply to information that has already been released in response to this authorization.
3. Once information is released pursuant to this authorization, the information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy rule, 45 CFR Parts 160 and 164.
4. With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: ☐ .Please indicate any restrictions: (Specify)_____.
5. This authorization must be filled out completely and signed and dated to be considered valid.
6. A copy of this authorization will be considered as valid as the original authorization.
7. Treatment, payment for services, enrollment and eligibility for benefits are not contingent upon signing of this authorization form.

1. *Daim ntawv tso cai hnub tas kas nuv yog ib lub xyoo tom qab hnub kuv kos npe rau daim ntawv tso cai.*
2. *Daim ntawv tso cai nos muab tshem tawm thaum twg los tau tsuas tus tub mob sau ntawv mus qhia rau qhov chaw nyob uas xav tau cov ntaub ntawv li saum toj nos. Daim ntawv sau mus tshem daim ntawv tso cai nos yuav muab siv tsis tau rau cov ntaub ntawv ua twb muab xav mus tag raws li daim ntawv tso cai.*
3. *Yog thaum twb xa cov ntaub ntawv raws li daim ntawv tso cai lawm nos ces, cov ntaub ntawv nos yuav tsis muaj kev tiv thiav los ntawm tsoom fwm txoj cai 45 ua tsis pub qhia tawm CFR txheej 160 thiab 164 vim cov ntaub ntawv twb tau muab xa mus rau lwm qhov chaw lawm.*
4. *Cov ntaub ntawv kuaj thaj maum nyuaj siab, tag nrho cov ntawv kuaj hlwb/cim seeb tsis zoo, siv dej cawv los yog tshauj yeeb thiab kev muaj mob xws li AIDS/HIV yuav pub qhib tawm tabsis yog tsis pub qhib tawm nos ces khij qhov nos:* ☐ *Thov sau txog txhua yam txwm tsis pub qhib tawm:(sau kom meej)* _____.
5. *Daim ntawv tso cai nos yuav tsum teb kom tiav thiab kos npe kom tag ua ntej yuav siv tau.*
6. *Daim ntawv tso cai uas muab luam dua tshiab yauv muab siv tau ib yam li daim tiag.*
7. *Kos npe rau hauv daim ntawv tso cai nos yuav txhais tsis tau tias yuav tau txais kev kuaj mob, kev pab them nyiak rau cov kev pab tau txais, ua ntawv ncuv npe kom tau txais nyiaj ntawm lav thab. npas.*

Patient's /Authorized Person's Signature / *Tus Tub Mob/Tus Neeg Muaj Cai Kos Npe:*

Signature of Patient/Authorized Person _____ **Date/*Vas nthib**** 04/15/2010

Tub mob kos lub npe/ Tus neeg muaj cai

Authorized Person's Authority to Sign/*Tus Neeg tau cai kos lub npe** _____

Reason Patient is unable to sign/*Vim li cas Tus Tub Mob kos tsis tau nws lub npe*: ☐ **Minor/*tsis tau muaj 18 xyoo*** ☐ **Deceased/*Tas sim neej***

☐ **Other/*Lwm yam*** _____

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PLEASE BE SURE ALL * AREAS ARE COMPLETE BEFORE SIGNING RELEASE.