HealthInfoNet

Foomka ogolaanshaha ka qayb galka Caafimaadka Maskaxda ama xogta HIV/AIDS

"Opt-in" Form for Mental Health or HIV/AIDS Information"

Haddii aanad doonayn in aad la wadaagto Caafimaadkaaga Maskaxda ama macluumaadka HIV/AIDS (oo aadan horey u buuxin) **waxba haku samayn foormkan.** Waxaad had iyo jeer dooran kartaa in aad u ogolaato Daryeel bixiye kasta in ay arkaan macluumaadkaaaga. Daryeel bixiyeyaashaada kale waxa kaliya oo ay awoodi karaan in ay eegaan macluumaadkaaga haddii aad ku jirto xaalad caafimaad oo dagdega ah.

Hadii adigu aad doonaysid inaad la wadaagto Caafimaadkaaga Maskaxeed ama macluumaadka HIV/AIDS yadoo ay isticmaalayaan daryeel bixiye yaashaadu "HealthInfoNet", fadlan sax mid ama in ka badan oo sanduuqyadan ah.

☐ Waxaan doonayaa in aan la wadaago xogtayda caafimaadka maskaxda daryeel bixiyahayga.
I want to share my mental health information with my providers.

☐ Waxaan doonayaa in aan la wadaago daryeel bixiyahayga xogtayda ku saabsan HIV/AIDS.
I want to share my HIV/AIDS information with my providers.

Haddii aad horey u ogolaatay inaad la wadaagto macluumaadkani, waxaad badali kartaa go'aankaaga. Si aad uga joojisid wadaagida daryeel bixiyEyaasha isticmaalaya "HealthInfoNet", marka laga reebo xaaladaha dagdaga ah, fadlan sax hal ama ka badan oo sanduuqyadan ah.

☐ MA DOONAYOin aan la wadaago xogtayda caafimaad maskaxda daryeel bixiyahayga.
I DO NOT want to share my mental health information with my providers.

☐ MA DOONAYO in aan la wadaago daryeel bixiyahayga xogtayda ku saabsan HIV/AIDS.
I DO NOT want to share my HIV/ AIDS information with my providers.

Haddii aad doonaysid in aad ka saartid dhammaan macluumaadkaaga caafimaad "HealthInfoNet" xitaa haddii ay tahay xaalad dagdag ah, fadlan buuxi foomka "iska-daynta" kaas oo diyaar ku ah www.hinfonet.org/optout ama adeeg bixiyehaaga.

Magaca Hore *(First Name)* Magaca Dhexe *(Middle Name)* Magaca Awowga *(Last Name)*

Cinwaan *(Address)* Magaalo *(City)* Gobolka *(State)* Siib koodhka *(Zip Code)*

Sinji: □ Lab *(Male)* □ Dheddig *(Female)*

Taariikhda Dhalashada *(Date of Birth)*: __ __ / __ __ / __ __ __ __ (bil / maalin / sanad)

__ __ __ – __ __ – __ __ __ __
Lambarka Caymiska Bulshada – Khasab ma aha inaad ku qorto *(Social Security Number – not required)*

Telefoonka maalintii *(daytime telephone)* imayl *(email)*

Saxeexa Bukaanka ama Masuulka *(Signature of Patient or Guardian)* Taariikhda *(Date)* __ __ / __ __ / 20 __ __ (bil / maalin / sanad)

To be signed by Healthcare Provider, Notary Public, or HealthInfoNet Staff
(Waa inuu saxeexaa Daryeel Bixiye, Nootaayo, ama Shaqaalaha HealthInfoNet)

On _____/____/20___, I attest that the above signer is personally known to me or established his/her identity by presenting government-issued photo identification.

Signature **Print Full Name** **Employer/Organization**

Fadlan waydii adeeg bixiyayaasha daryeelka ama nootayada bulshada in aad saxeexdo sanduuqa xaga sare iyo inaad tustid sawirka I.D. dawladu ku siisayas. **Markaad saxeexdo, fadlan noogu soo dir foomkani HealthInfoNet, 125 Presumpscot Street, Box 8, Portland, ME 04103 amma fagas-kan (fagas) 207-541-9258**. Haddii aad hayso wax su'aalo ah ama aad u baahan tahay caawimo si aad foomkani u saxiixdo, waxaad anaga naga soo wacdaa 1-866-592-4352 ama iimayl noogu soo dirtaa info@hinfonet.org.