DEPARTMENT OF HEALTH

BOGGA 1 EE 2
DIB-LOO-EEGAY 02/2025

Codsiga Baahinta
Ogolaanshaha Baahinta Kaarka Baaritaanka Ilmaha Dhashay

Request to Release Authorization to Release Newborn Screening Card
Somali
Authorization to release protected health information to an interpreter (Somali)

Magaca Ilmaha (Koobaad. Sadexaad):
Child's name (first & last):

Taariikhda Dhalashada:
Birth date:

Magaca hooyada dhashay (Koobaad. Sadexaad):
Birth mother's name (first & last):

Isbitaalka ama meesha uu ku dhashay:
Hospital or place of birth:

Waan fahmayaa waxyaabaha soo soda:

- Marka aan buuxiyo aana ku celiyo foomkaan, waxaan codsanayaa in kaarka baaritaanka ilmaha dhashay ee ilmaha magaciisa kor lagu sheegay la siiyo dhakhtarka iyo/ama rugta caafimaadka ee magaceedu hoos ku yaalo.
- Marka kaarka baaritaanka ilmaha dhashay la siiyo dhakhtarka ama rugta caafimaadka, Minnesota Department of Health ayaa maamuli karin in dkhakhtarta ama rugta caafimaadku kaarka la wadaagto dhinacyo kale. La xiriir dhakhtarka ama rugta haddii aad su'aalo ka qabto xeerarkooda sirta iyo farsamooyinka.
- Si ay u dhaqan gasho, foomkaan waa in si buuxda uu u buuxiyaa uuna u saxiixaa qofka ama masuulka sharciga ah ee ilmuhu. Nuqul ayaa dhaqan galaaya haddii aan waxba laga badelin.

I understand the following:

- By completing and returning this form, I request the above-named child's used newborn screening card(s) be released to the health care provider and/or clinic named below.
- Once the newborn screening card(s) are released to the health care provider or clinic, the Minnesota Department of Health cannot control whether the provider or clinc shares the card(s) with others. Contact the provider of clinic if you have questions about their privacy policies and practices.
- To be valid, this form must be filled out completely and signed by the individual or the legal guardian of the minor. A copy is valid if it has not been altered.

Magaca farta waawayn ku qoran ee waalidka/masuulka codsanaaya (Koobaad iyo Sadexaad):
Requesting parent/guardian's printed name (first & last):

Saxiixa waalidka ama masuulka:
Parent or guardian signature:

Xariirka Kala dhexeeya ilmaha:
Relationship to child:

Taariikhda maanta:
Today's date:

Ciwaanka Wadada:
Street address:

Magaalada:
City:

Gobalka:
State:

Boostada:
Zip

Taleefanka:
Phone:

Ciwaanka Boostada Dhakhtarka ama Rugta Caafimaadka

Ujeedo:
Attention:

Ciwaanka Laynka 1:
Address line 1:

Ciwaanka Wadada

Ciwaanka Laynka 2:
Address line 2:

Dabaqa, qaybta, guriga, dhismaha, dabaqa, iwm. (ma gayn kaarno sanduuqa Boostada)

Magaalada:
City:

Gobalka:
State:

Boostada:
Zip:

Taleefanka:
Phone:

U dir foomka la buuxshay:
Minnesota Department of Health
Newborn Screening Program
P.O. Box 64899
St. Paul, MN 55164-0899

Teleefoonka: (800) 664-7772
Fakiska: (651) 215- 6285
Iimeylka: health.newbornsceening@state.mn.us
Webseedka: www.health.state.mn.us/newbornscreening