

| | | | |
|--------------------------------------|-----------------|---------------------------|-------------------------------------|
| Tus neeg mob lub npe Patient name | | | |
| MHN MHN | Hnub yug DOB | Muaj tsawg xyoo Age | Poj niam los txiv neej Gender |

**Kev Kho Me Nyuam Yaus/Tus Laus Hauv Chaw Tiv Thaiv Thaum Tsis Muaj Niam Txiv/
Tus Neeg Saib Xyuas Nyob Rau Ntawd**

Rho Tawm Txoj Kev Tso Cai

**Consent Revocation - Treatment of Minor/Adult Ward
in Parent/Legal Guardian Absence**

Nplooj 1 ntawm 1

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Tus neeg mob qhov chaw nyob _____
Patient address

Nroog _____ Xeev _____ Zauv Cheeb Tsam (ZIP) _____
City State ZIP

Tus xov tooj hauv tsev _____
Home telephone number

Ntawm no kuv rho tawm daim ntawv Tso Cai – Kho Cov Me Nyuam Tsis Tau Muaj Hnub Nyoog thaum Niam Txiv/Tus Neeg Saib Xyuas Tsis Nyob Rau Ntawd los sis daim ntawv Tso Cai – Kho Tus Laus Hauv Chaw Tiv Thaiv Thaum Tus Neeg Saib Xyuas Tsis Nyob Rau Ntawd uas kuv tau ua rau thaum

I hereby revoke the Consent – Treatment of Minors in Parent/Legal Guardian Absence or Consent – Treatment of Adult Ward Legal Guardian Absence form(s) generated by me on

(hnub time: hli/hnub/xyoo) _____ / _____ / _____ rau:
(date: month/day/year) to:

Tus neeg/Lub koom haum saib xyuas lub npe _____
Appointee name

Qhov chaw nyob _____
Address

Nroog _____ Xeev _____ Zauv Cheeb Tsam (ZIP) _____
City State ZIP

Kuv nkag siab tias yuav siv tsis tau qhov kev rho tawm daim ntawv Tso Cai – Kho Cov Me Nyuam Tsis Tau Muaj Hnub Nyoog thaum Niam Txiv/Tus Neeg Saib Xyuas Tsis Nyob Rau Ntawd los sis daim ntawv Tso Cai – Kho Tus Laus Hauv Chaw Tiv Thaiv Thaum Tus Neeg Saib Xyuas Tsis Nyob Rau Ntawd yog tias Marshfield Clinic Health System twb tau siv los sis pub tso cai kho thaum siv qhov kuv tso cai lawm.

I understand that this revocation of the Consent – Treatment of Minors in Parent/Legal Guardian Absence or Consent – Treatment of Adult Ward Legal Guardian Absence form(s) will not be valid if Marshfield Clinic Health System has already used or allowed for the consenting of care in reliance upon my authorization.

Tus neeg mob kos npe (Tus neeg uas tau kev pom zoo los tso cai rau tus neeg mob)
Patient signature (Person authorized to consent for patient)

(Kev sib txeeb rau tus neeg mob)
(Relationship to patient)

_____/_____/_____
Kos npe hnub tim (hli/hnub/xyoo)
Signature date (month/day/year)

**Xa daim ntawv thov uas teb mee mus rau: Health Information Management, Marshfield Clinic Health System,
2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consent@marshfieldclinic.org
Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive,
Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consent@marshfieldclinic.org**