

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

**Tus Neeg Mob Saib Tau**

## Daim Ntawv Thov Muab Ntaub Ntawv Qhia Tawm

### Release of Information Request - Patient Access

Nplooj 1 ntawm 2

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Tus neeg mob chaw nyob Patient address		Hnub tim thov (hli/hnub/xyoo) Request date (month/day/year) / /
Nroog City	Xeev State	Zauv cheeb tsam ZIP code

**HOM KEV SAIB THIAB COV NTAUB NTAUV THOV TXOG****TYPE OF ACCESS AND INFORMATION REQUESTED**

Koj xav saib los yog xav tau koj cov ntaub ntawv ua qauv:  Kuaj hauv no  Tau ua qauv  
 Would you like to inspect or obtain a copy of your records: *Inspect on-site* *Copy*

Rau hom ntaub ntawv twg:  Kuv cov ntaub ntawv kho mob  Kuv cov ntaub ntawv kho kev puas hlwb  
 For what type of record: *My medical records* *My mental health records*

Kuv cov ntaub ntawv them nqi  Kuv cov ntawv qhia seb soj ntsuam tau dab tsi  
*My billing records* *My test results*

Kuv cov duab yees fais  Lwm yam, qhia seb yog dab tsi \_\_\_\_\_  
*My radiology images* *Other, specify*

Rau lub sij hawm twg: Thaum (hli/hnub/xyoo) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ txog (hli/hnub/xyoo) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 For what time period: From (m/d/y) to (m/d/y)

Tag nrho (All)  Cov kho tshiab (Update)

Hom kev qhia tawm:  Ntawv  
 Method of release: *Paper*

Sau ntawv (Siv ib cov ntawv los nab npawm thiaj qhib tau) Chaw nyob \_\_\_\_\_  
*Emailed (Use of encryption required)* *Address*

Tuaj nqa (tus xov tooj hu tau \_\_\_\_\_ Xav kom tuaj nqa hauv center \_\_\_\_\_)  
*Pick-up (number to call)* *Preferred Center for pick-up*

Xa hauv kev xa ntawv tuaj (Qhia lub npe thiaj qhov chaw nyob rau hauv qab no):  
*Mailed (Specify the name and address below):*

Npe (Name) \_\_\_\_\_

Chaw nyob (Address) \_\_\_\_\_

Lub hom phiaj ntawm qhov kev thov no yog:  Kev kho mob mus txuas ntxiv  Rau tus kheej  
 The purpose of this request is: *Continuing health care needs* *Personal*

Pauv kev kho mob  Kev hais plaub  Kev tawm tswv yim zaum ob/kev xa mus cuag  
*Transfer of care* *Litigation* *Second opinion/referral*

Kev txiav txim txog kev tsis taus (rau kev tuav pov hwm los sis nom tswv)  
*Disability determination (for insurance or government)*

Lwm yam, qhia seb yog dab tsi \_\_\_\_\_  
*Other, specify*

**Tus Neeg Mob Saib Tau**

**Daim Ntawv Thov Muab Ntaub Ntawv Qhia Tawm (Txuas mus)**

Nplooj 2 ntawm 2

Tus neeg mob lub npe <i>Patient name</i>	MHN <i>MHN</i>	Hnub yug <i>DOB</i>	Muaj tsawg xyoo <i>Age</i>	Poj niam los txiv neej <i>Gender</i>
<p>Kuv nkag siab tias Marshfield Clinic Health System yuav qhia rau kuv txog nws txoj kev txiav txim seb pom zoo los sis tsis pom zoo rau kuv qhov kev thov los saib los sis tau kuv cov ntaub ntawv ua qauv li ntawm peb caug (30) hnub tom qab tau txais qhov kev thov no yog tias cov ntaub ntawv yog ceev rau ntawm chaw los sis saib tau ntawm chaw los sis li ntawm rau caum (60) hnub yog tias cov ntaub ntawv tsis yog ceev rau ntawm chaw los sis saib tsis tau ntawm chaw. Yog tias Marshfield Clinic Health System ua tsis tau raws li kuv txoj kev thov cov ntaub ntawv uas ceev rau ntawm chaw los sis saib ntawm chaw li ntawm peb caug (30) hnub, nws yuav rub lub sij hawm mus txog peb caug (30) hnub ntxiv uas sau ntawv tuaj qhia rau kuv paub.</p> <p><i>I understand that Marshfield Clinic Health System will notify me of its decision to approve or deny my request to inspect or obtain a copy of my records within thirty (30) days of receiving this request if the information is maintained or accessible on-site or within sixty (60) days if the information is not maintained or accessible on-site. If Marshfield Clinic Health System is unable to comply with my approved request for information maintained or accessible on-site within thirty (30) days, it may extend the deadline for up to thirty (30) more days by notifying me in writing.</i></p> <p>Tshwj tsis yog tias pub ua raws li hauv txoj cai uas siv, kuv nkag siab tias kuv muaj cai kom ib tug kws kho mob uas muaj ntawv tso cai los soj ntsuam kuv txoj kev thov uas raug tsis pom zoo rau uas Marshfield Clinic Health System ua tus xaiv thiab nws tsis koom rau hauv Marshfield Clinic Health System txoj kev txiav txim los muab kev tsis pom zoo rau kuv qhov kev thov. <i>Except as otherwise allowed under applicable law, I understand that I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Marshfield Clinic Health System who did not participate in Marshfield Clinic Health System's decision to deny my request.</i></p>				
Tus neeg mob xee npe (Tus neeg muaj cai tso cai kos npe rau tus neeg mob) <i>Patient signature (Person authorized to consent for patient signature)</i>	(Kev sib txeeb rau tus neeg mob) <i>(Relationship to patient)</i>	Kos npe hnub tim (hil/hnub/xyoo) <i>Signature date (m/d/y)</i>	Xov tooj <i>Phone number</i>	
Tus neeg mob tsis tau muaj hnub nyooq kos npe (yog ua tau) <i>Minor patient signature (if applicable)</i>		Kos npe hnub tim (hil/hnub/xyoo) ____ / ____ / ____ <i>Signature date (m/d/y)</i>		

**Xa daim ntawv thov uas teb mee mus rau: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: [medicalrecords@marshfieldclinic.org](mailto:medicalrecords@marshfieldclinic.org)**

**Forward completed request to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: [medicalrecords@marshfieldclinic.org](mailto:medicalrecords@marshfieldclinic.org)**

<b>FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY</b>	Date received (m/d/y) ____ / ____ / ____
<input type="checkbox"/> Accepted <input type="checkbox"/> Denied If denied, check reason for denial: <input type="checkbox"/> PHI is compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding <input type="checkbox"/> PHI is not available to the patient for inspection or copying as permitted or required by state or federal law <input type="checkbox"/> PHI is not part of patient's designated record set <input type="checkbox"/> Other (see comments below)	
Comments: <input type="checkbox"/> Individual was informed of denial in writing (attach letter of communication)	
Staff member signature/title	Date (month/day/year) ____ / ____ / ____