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

Nplooj 1 ntawm 2

Release of Information Request – Patient Access

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 NTAWV 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 thiab 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)

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

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.

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 informa-tion is not maintained or accessible on-site. If Marshfield Clinic Health Systtem 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.

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.
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.

_____ Tus neeg mob xee npe (Tus neeg muaj cai tso cai kos npe rau tus neeg mob) *Patient signature (Person authorized to consent for patient signature)*	_____ (Kev sib txeeb rau tus neeg mob) *(Relationship to patient)*	_____ /_____ /_____ Kos npe hnub tim (hil/hnub/xyoo) *Signature date (m/d/y)*	_____ Xov tooj *Phone number*

Tus neeg mob tsis tau muaj hnub nyoog kos npe (yog ua tau) _____
Minor patient signature (if applicable)

Kos npe hnub tim (hil/hnub/xyoo) _____ /_____ /_____
Signature date (m/d/y)

Xa daim ntawv thov uas teb meej 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

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

FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY

Date received (m/d/y) _____ /_____ /_____

☐ Accepted ☐ Denied

If denied, check reason for denial:

☐ PHI is compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding

☐ PHI is not available to the patient for inspection or copying as permitted or required by state or federal law

☐ PHI is not part of patient's designated record set

☐ Other (see comments below)

Comments: ☐ Individual was informed of denial in writing (attach letter of communication)

_____ _____ /_____ /_____
Staff member signature/title Date (month/day/year)

