

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

**Lus Txwv Los Ntawm Tus Neeg Mob**

**KeV Thov Qhia Tawm Cov Ntaub Ntawv Kho Mob**

Nplooj 1 ntawm 2

**Release of Information Request - Restrictions by Patient**

Page 1 of 2

Hnub tim thov (hli/hnub/xyoo) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Request date (month/day/year)

Tus neeg mob qhov chaw nyob \_\_\_\_\_  
Patient address

Nroog \_\_\_\_\_ Xeev \_\_\_\_\_ Zauv Cheeb Tsam \_\_\_\_\_  
City State ZIP

**Xav kom txwv dab tsi  
What needs to be restricted**

Piav qhia seb koj xav kom txwv kev siv los sis kev qhia tawm dab tsi ntawm koj cov ntaub ntawv kho mob los kho, them nqi los sis khiav dej num hauv txoj kev kho mob.  
Explain how you wish us to restrict uses or disclosures of your health information to carry out treatment, payment or health care operations.

\_\_\_\_\_

\_\_\_\_\_

Piav qhia seb koj xav kom peb txwv cov kev qhia tawm koj cov ntaub ntawv kho mob rau:  
Explain how you wish us to restrict disclosures of your health information to:

- koj tsev neeg los sis lwm tus neeg uas koj qhia npe tias muaj feem koom hauv txoj kev kho koj los sis kev them cov nqi kho koj  
your family member or other person identified by you as being involved in your care or payment for your care
- ib tug neeg los sis koom haum rau kev pab thaum muaj kev kub ntxhov  
a person or organization for disaster relief purposes

\_\_\_\_\_

\_\_\_\_\_

Kuv nkag siab tias Marshfield Clinic Health System tsis tas yuav pom zoo rau kuv txoj kev thov txwv cov kev siv los sis kev qhia tawm kuv cov ntaub ntawv kho mob.  
I understand that Marshfield Clinic Health System is not required to agree to my request to restrict uses and disclosures of my health information.

\_\_\_\_\_  
Tus neeg mob kos npe (Tus neeg muaj cai los tso cai rau tus neeg mob) (Kev sib txeeb rau tus neeg mob) Kos npe hnub tim (hil/hnub/xyoo) Xov tooj  
Patient signature (Patient's legal representative) (Relationship to patient) Signature date (month/day/year) Phone number

**Xa daim ntawv thov uas teb mee mus rau: Health Information Management, HM2, Marshfield Clinic Health System, 1000 North Oak Avenue, Marshfield, WI 54449 Fax: 715-221-5847 E-mail: mfld.him.scanners@marshfieldclinic.org**  
**Send completed request to: Health Information Management, HM2, Marshfield Clinic Health System, 1000 North Oak Avenue, Marshfield, WI 54449 Fax: 715-221-5847 E-mail: mfld.him.scanners@marshfieldclinic.org**

**Lus Txwv Los Ntawm Tus Neeg Mob**

**Key Thov Qhia Tawm Cov Ntaub Ntawv Kho Mob (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 sis txij neej <i>Gender</i>
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**FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY**

Date received (m/d/y) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Accepted     Denied

If denied, check reason for denial:

- PHI was not created by Marshfield Clinic Health System
- PHI cannot be restricted for quality and continuity of care reasons
- Request is for restriction of uses or disclosures of PHI for purposes other than treatment, payment or health care operations
- Request is for restriction of disclosures of PHI for other than 164.510(b) purposes

Comments:

- Individual was informed of denial in writing (attach letter of communication)

\_\_\_\_\_  
Staff member signature/title

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (month/day/year)