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

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 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

Send completed form to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

