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

Daim Ntawv Teev Cov Kev Qhia Tawm

Daim Ntawv Thov Qhia Tawm

Nplooj 1 ntawm 2

Release of Information Request – Accounting of Disclosures

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 code*

Kuv xav tau ib daim ntawv teev cov kev qhia tawm kuv cov ntaub ntawv kho mob uas Marshfield Clinic Health System tau qhia tawm thaum (sau hnub tim) _____ txog rau _____ .
to

I would like an accounting (list) of disclosures of my health information made by Marshfield Clinic Health System from (insert dates).

Thaum txais tau tsab ntawv sau thov, Marshfield Clinic Health System yuav muab ib daim ntawv teev tag nrho cov kev qhia tawm thaum hauv lub sij hawm rau (6) xyoo ua ntej hnub tim thov kom muab daim ntawv teev.
Upon receipt of a written request, Marshfield Clinic Health System will provide the requestor with an accounting of all accountable disclosures during the six (6) year period immediately prior to the date of the request for an accounting.

Kuv xav kom tus tswj xyuas nyiaj txiag xa ntawv/es mias rau kuv rau ntawm qhov chaw nyob:
I would like this accounting to be mailed/emailed to me at the following address:

_____

Kuv nkag siab tias daim ntawv teev cov kev qhia tawm uas kuv tau thov yuav **tsis** muaj cov kev qhia tawm nram qab no nyob rau hauv:
*I understand that the accounting of disclosures I have requested will **not** include the following types of disclosures:*

- Cov kev qhia tawm kom kho tau kuv, cov kev them nqi thiab kev khiav dej num kho mob
  Disclosures to carry out my treatment, payment and health care operations activities
- Cov kev qhia tawm rau kuv los sis kuv tus neeg sawv cev kuv raws txoj cai
  Disclosures to me or my legal representative
- Cov kev qhia tawm uas kuv tau sau ntawv tso cai
  Disclosures for which I signed a written authorization
- Cov kev qhia tawm rau cov neeg uas muaj feem rau txoj kev kho kuv los sis rau lwm cov kev qhia kom paub
  Disclosures to persons involved in my care or other notification purposes
- Cov kev qhia tawm rau kev tiv thaiv teb chaws los sis kev nyiag tswv yim los ntawm yus tus yeeb ncuab
  Disclosures for national security or intelligence purposes
- Cov kev qhia tawm rau cov tsev kaw neeg ua txhaum cai los sis rau tub ceev xwm uas muaj cai saib xyuas kuv
  Disclosures to correctional institutions or law enforcement officials having lawful custody of me
- Cov kev qhia tawm uas ua ib feem ntawm cov ntaub ntawv qhia rau pej xeem txoj kev noj qab haus huv los sis kev khiav dej num hauv kev kho mob
  Disclosures made as part of a limited data set for public health, research or health care operations activities

Daim Ntawv Teev Cov Kev Qhia Tawm

Daim Ntawv Thov Qhia Tawm (Txuas mus)

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

Kuv tseem nkag siab mus txuas ntxiv tias Marshfield Clinic Health System yuav muab thawj daim ntawv teev cov kev qhia tawm hauv kaum ob (12) lub hlis twg pub dawb rau kuv tiam sis Marshfield Clinic Health System yuav kom kuv them ib tug nqi rau cov kev thov kom muab daim ntawv teev tom qab ntawd uas tseem nyob hauv tib lub sij hawm kaum ob (12) lub hlis.

I further understand that Marshfield Clinic Health System will provide me with the first accounting of disclosures in any twelve (12) month period without charge but Marshfield Clinic Health System may impose a reasonable fee for each subsequent request I make for an accounting of disclosures within the same twelve (12) month period.

_____ Tus neeg mob kos npe (Tus neeg muaj cai 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 (hil/hnub/xyoo) *Signature date (month/day/year)*	_____ Xov tooj *Phone number*

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

FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY Date received (m/d/y) _____ /_____ /_____

☐ Accepted ☐ Denied

☐ Temporarily suspended of right to accounting based on written or oral statement from a health oversight agency or law enforcement official

☐ _____

_____

Comments:

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

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

