

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

**Daim Ntawv Qhia Kom Rho Tawm Kev
Qhia Tawm Cov Ntaub Ntawv
Release of Information Revocation Notice**

Tus neeg mob qhov chaw nyob _____
Patient address

Nroog _____ Xeev _____ Zauv Cheeb Tsam _____
City State ZIP

Tus xov tooj hauv tsev _____
Home telephone number

Ntawm no kuv tso cai rho tawm Daim Ntawv Tso Cai Qhia Tawm Cov Ntaub Ntawv uas kuv tau ua rau thaum
I hereby revoke the Release of Information Authorization generated by me on

(hnub tim: hli/hnub/xyoo) _____ / _____ / _____ rau:
(date: month/day/year) to:

Tus neeg los sis lub koom haum npe _____
Person or organization name

Qhov chaw nyob _____
Address

Nroog _____ Xeev _____ Zauv Cheeb Tsam _____
City State ZIP

**Kuv nkag siab tias qhov kev rho tawm Daim Ntawv Tso Cai Qhia Tawm Cov Ntaub Ntawv yuav siv tsis tau rau kuv cov
ntaub ntawv kho mob uas Marshfield Clinic Health System twb tau siv los sis qhia tawm lawm raws li qhov kuv tau tso cai.
I understand that this revocation of the Release of Information Authorization will not be valid where Marshfield Clinic
Health System has already used or disclosed my health information in reliance upon my authorization.**

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 (hli/hnub/xyoo)
Signature date (month/day/year)

**Xa daim ntawv thov uas teb meej mus rau: Health Information Management, HM2, Marshfield Clinic Health System,
1000 North Oak Avenue, Marshfield, WI 54449 Fax: 715-389-0564 E-mail: him.specialconditions@marshfieldclinic.org
Send completed form to: Health Information Management, HM2, Marshfield Clinic Health System, 1000 North Oak Avenue,
Marshfield, WI 54449 Fax: 715-389-0564 E-mail: him.specialconditions@marshfieldclinic.org**