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

Sau Cia/Qhia Tseg Txug Kev Mob Nkeeg

Daim Ntawv Thov Muab Ntaub Ntawv Qhia Tawm

Nplooj 1 ntawm 2

Release of Information Request – Amendment/Correction of Health Information

Page 1 of 2

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*

YUAV TAU HLOOV/KHO DAB TSI THIAB YOG VIM LI CAS
WHAT NEEDS TO BE AMENDED/CORRECTED AND WHY

Nqe yuav tau hloov _____
Entry to be amended

Hnub tim sau (hli/hnub/xyoo) _____ /_____ /_____ Tus neeg sau _____
Date of entry (month/day/year) *Author of entry*

Piav qhia seb koj cov ntaub ntawv kho mob nws tsis yog los sis tsis tiav li cas. Koj cov ntaub ntawv kho mob yuav tsum tau hais li cas thiaj li yog los sis tiav.
Explain how your health information is incorrect or incomplete. What should your health information state to be more accurate or complete.

Koj puas xav kom xa cov ntaub ntawv no mus rau cov neeg uas tej zaum peb tau qhia tawm cov ntaub ntawv rau yav tas los:
Would you like this information sent to anyone to whom we may have disclosed this information in the past:

☐ Xav *(Yes)* ☐ Tsis xav *(No)*

Yog xav, qhia lub npe thiab qhov chaw nyob ntawm lub koom haum los sis tus neeg:
If yes, specify the name and address of the organization or individual:

Npe *(Name)* _____

Qhov chaw nyob *(Address)* _____

Kuv nkag siab tias Marshfield Clinic tej zaum yuav hloov los sis tsis hloov kuv cov ntaub ntawv kho mob kom muaj daim ntawv hloov raws li qhov kuv tau thov. Qhov kev thov kom hloov no yuav muab tso ua ib feem nyob mus tas li hauv kuv cov ntaub ntawv kho mob.
I understand that Marshfield Clinic may or may not amend my medical record with an amendment based on my request. This request for an amendment will be made part of my permanent medical record.

_____	_____	_____ /_____ /_____	_____
Tus neeg mob kos npe (Tus neeg muaj cai los tso cai rau tus neeg mob) *Patient signature (Patient's legal representative)*	(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*

Tus menyuam mob tsis tau muaj hnub nyug sau npe no (yog tias sau tau) _____ Sau npe hnub tim (hil/hnub/xyoo) ____ /____ /____
Minor patient signature (if applicable) *Signature date (m/d/y)*

Xa daim ntawv thov uas teb meej mus rau: Release of Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

Forward completed request to: Release of Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

Sau Cia/Qhia Tseg Txog Kev Mob Nkeeg

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 sis txiv neej *Gender*

FOR MARSHFIELD CLINIC INTERNAL USE ONLY

Date received (month/day/year) _____ /_____ /_____

☐ Accepted ☐ Denied

If denied, check reason for denial:

☐ PHI was not created by Marshfield Clinic ☐ Other (specify) _____

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

☐ PHI is accurate and complete

Comments:

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

_____ _____ /_____ /_____

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