

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

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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 thiaib 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 Health System 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 Health System 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) Minor patient signature (if applicable)		Sau npe hnub tim (hil/hnub/xyoo) ____ / ____ / ____ Signature date (m/d/y)	

Xa daim ntawv thov uas teb mee 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

Forward completed request to: Release of Information, Marshfield Clinic Health System, 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)

Nplooj 2 ntawm 2

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

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)