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

Lus Txwv Los Ntawm Tus Neeg Mob

Kev Thov Qhia Tawm Cov Ntaub Ntawv Kho Mob

Nplooj 1 ntawm 2

Release of Information Request – Restrictions by Patient

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*

Xav kom txwv dab tsi
What needs to be restricted

Piav qhia seb koj xav kom txwv kev siv los sis kev qhia tawm dab tsi ntawm koj cov ntaub ntawv kho mob los kho, them nqi los sis khiav dej num hauv txoj kev kho mob.
Explain how you wish us to restrict uses or disclosures of your health information to carry out treatment, payment or health care operations.

Piav qhia seb koj xav kom peb txwv cov kev qhia tawm koj cov ntaub ntawv kho mob rau:
Explain how you wish us to restrict disclosures of your health information to:

– koj tsev neeg los sis lwm tus neeg uas koj qhia npe tias muaj feem koom hauv txoj kev kho koj los sis kev them cov nqi kho koj
your family member or other person identified by you as being involved in your care or payment for your care

– ib tug neeg los sis koom haum rau kev pab thaum muaj kev kub ntxhov
a person or organization for disaster relief purposes

Kuv nkag siab tias Marshfield Clinic tsis tas yuav pom zoo rau kuv txoj kev thov txwv cov kev siv los sis kev qhia tawm kuv cov ntaub ntawv kho mob.
I understand that Marshfield Clinic is not required to agree to my request to restrict uses and disclosures of my health information.

_____	_____	_____ /_____ /_____	_____
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 (hli/hnub/xyoo) *Signature date (month/day/year)*	Xov tooj *Phone number*

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

Lus Txwv Los Ntawm Tus Neeg Mob

Kev Thov Qhia Tawm Cov Ntaub Ntawv Kho Mob (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*

RAU MARSHFIELD CLINIC COV NEEG SAB HAUV SIV XWB
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
- ☐ PHI cannot be restricted for quality and continuity of care reasons
- ☐ Request is for restriction of uses or disclosures of PHI for purposes other than treatment, payment or health care operations
- ☐ Request is for restriction of disclosures of PHI for other than 164.510(b) purposes

Comments:

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

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

