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 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 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) (Kev sib txeeb rau tus neeg mob) Kos npe hnub tim (hil/hnub/xyoo)
Patient signature (Person authorized to consent for patient) *(Relationship to patient)* *Signature date (month/day/year)*

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

