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 code  

Kuv xav tau ib daim ntawv teev cov kev qhia tawm kuv cov ntaub ntawv kho mob uas Marshfield Clinic Health
System tau qhia tawm thaum (sau hnub tim) __________________________ txog rau ______________________ .

to

I would like an accounting (list) of disclosures of my health information made by Marshfield Clinic Health System from (insert dates).

Thaum txais tau tsab ntawv sau thov, Marshfield Clinic Health System yuav muab ib daim ntawv teev tag nrho cov kev qhia
tawm thaum hauv lub sij hawm rau (6) xyoo ua njei hnub tim thov kom muab daim ntawv teev.

Upon receipt of a written request, Marshfield Clinic Health System will provide the requestor with an accounting of all
accountable disclosures during the six (6) year period immediately prior to the date of the request for an accounting.

Kuv xav kom tus tswj xyuas nyiaj txiag xa ntawv/es mias rau kuv rau ntawm qhov chaw nyob: I would like this accounting to be mailed/emailed to me at the following address:

Kuv nkag siab tias daim ntawv teev cov kev qhia tawm uas kuv tau thov yuav tsis muaj cov kev qhia tawm nram qab
no nyob rau hauv:
I understand that the accounting of disclosures I have requested will not include the following types of disclosures:

• Cov kev qhia tawm kom kho tau kuv, cov kev them nqi thiab kev khiav dej num kho mob
Disclosures to carry out my treatment, payment and health care operations activities

• Cov kev qhia tawm rau kuv los sis kuv tus neeg sawv cev kuv raws tsoj cai
Disclosures to me or my legal representative

• Cov kev qhia tawm uas kuv tau sau ntawv tso cai
Disclosures for which I signed a written authorization

• Cov kev qhia tawm rau cov neeg uas muaj feem rau txoj kev kho kuv los sis rau lwm cov kev qhia kom paub
Disclosures to persons involved in my care or other notification purposes

• Cov kev qhia tawm rau kev tiv thav teb chaws los sis kev nyiag tswv yim los ntawm yus tus yeeb ncub
Disclosures for national security or intelligence purposes

• Cov kev qhia tawm rau cov tsev kaw neeg ua txhaum cai los sis rau tub ceev xwm uas muaj cai saib xyuas kuv
Disclosures to correctional institutions or law enforcement officials having lawful custody of me

• Cov kev qhia tawm uas ua ib feem ntawm cov ntaub ntawv qhia rau pej xeev tsoj kev noj qab haus huv los sis
kev khiav dej num hauv kev kho mob
Disclosures made as part of a limited data set for public health, research or health care operations activities
**Release of Information Request – Accounting of Disclosures**

**For Marshfield Clinic Health System internal use only**

<table>
<thead>
<tr>
<th>Tus neeg mob lub npe</th>
<th>MHN</th>
<th>Muaj yug</th>
<th>Poj niam las sib txiv neej</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tus neeg mob kos npe (Tus neeg muaj cai los too cai rau tus neeg mob)</td>
<td>MHN</td>
<td>DOB</td>
<td>Gender</td>
</tr>
</tbody>
</table>

| Kuv tseem nkag siab mus txuas ntxiv tias Marshfield Clinic Health System yuav muab thawj daim ntawv teev cov kev qhia tawm hauv kaum ob (12) lub hlis twg pub dawb rau kuv tiam sis Marshfield Clinic Health System yuav kom kuv them ib tug nqi rau cov kev thov kom muab daim ntawv teev tom qab ntawd uas tseem nyob hauv tib lub sij hawm kaum ob (12) lub hlis. |

I further understand that Marshfield Clinic Health System will provide me with the first accounting of disclosures in any twelve (12) month period without charge but Marshfield Clinic Health System may impose a reasonable fee for each subsequent request I make for an accounting of disclosures within the same twelve (12) month period.

<table>
<thead>
<tr>
<th>Tus neeg mob kos npe (Tus neeg muaj cai los too cai rau tus neeg mob)</th>
<th>Kos npe hnuub tim (hil/hnuub/xyoo)</th>
<th>Signature date (month/day/year)</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient signature (Person authorized to consent for patient)</td>
<td>(Relationship to patient)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date received (m/d/y) _____ / _____ / _____**

- [ ] Accepted
- [ ] Denied

- [ ] Temporarily suspended of right to accounting based on written or oral statement from a health oversight agency or law enforcement official

**Comments:**

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

**Staff member signature/title**

Date (month/day/year)