Reset Form

Attachment C: Tracking Form for Disclosure of Protected Health Information

Instructions: Please complete this form for each disclosure of protected health information (PHI) to an outside person, entity or organization where the patient's written authorization was **not** obtained. Do not complete this form if the PHI was released for continuing care or treatment, payment purposes, or health care operations. See Policy on Accounting of Disclosures of Protected Health Information for additional information.

Patient Name:		**Social Security Number:**	
Medical Record Number:		**Billing Number:**	
Date(s) of Disclosure:		**Date(s) of Service / Visit Disclosed:**	

Name of Person or Entity Receiving PHI: (Include address if known)	
If a Written Request was Received, attach the request and check box to the right.	☐ A written request for disclosure of the PHI was received from someone other than the patient and is attached to this form.
Brief Description of PHI Disclosed: (Check one, or all that apply)	☐ Demographic Information; such as name, address, telephone number or other contact data. ☐ Diagnosis or procedure information ☐ Lab test results, specify: _____ ☐ Radiology results, specify: _____ ☐ History or physical examination ☐ Discharge summary ☐ Consultation ☐ Entire medical record ☐ Emergency record of treatment ☐ Itemized bill or billing information ☐ Other, specify: _____
Brief Statement of Purpose of Disclosure:	☐ State or federal law required reporting (such as reporting births, deaths, communicable diseases, FDA, suspected abuse, crime victims & injuries) ☐ Organ donation or transplantation ☐ Medical examiner ☐ Funeral home ☐ Research ☐ Subpoena, court order, or other lawful process; see attached document ☐ Other, specify: _____

Person Completing Form: _____ **Title:** _____
Telephone: _____ **Date:** _____

Please forward this completed form to Medical Records.