

DISCLOSURE RECORD

Use this form to document each disclosure of protected health information for any purpose other than (a) to carry out treatment, payment activities or health care operations, (b) disclosures made to an individual, or (c) disclosures pursuant to written authorization provided by or on behalf of the individual.

Individual whose Protected Health Information was Disclosed

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

Disclosure Date: _____

Name/Address of Person or Entity to whom the Protected Health Information was Disclosed:

Protected Health Information Disclosed:

Purpose of Disclosure:

Multiple Disclosures

If a disclosure is one of a series of repetitive disclosures to the same person or entity for the same purpose, (a) state the date of the first disclosure; (b) the frequency, periodicity or number of the disclosures; and (c) the date of the last disclosure.

Verification of Identity and Authority

Identity: Record how identity was verified (for example, by confirming Social Security number, policy number, date of birth, or similar individual information) or attach copies of identification documents presented (for example, driver's license, passport, or other picture identification).

Authority: Record the basis for that claimed authority or attach copies of authorizing documents (for example, letters testamentary or of administration with respect to a deceased individual, power-of-attorney form, subpoena or court order, law enforcement badge or identification card, or similar authorizing document).

Disclosure With Authorization

If the disclosure was made pursuant to the individual's authorization, attach the completed authorization form.

Authorized Signature: _____ Date: _____
Print Name: _____ Title: _____