Please Complete Highlighted Blue Section Only

PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

Patient Name: ____________________ **DOB:**______/______/______
Month Day Year

AUTHORIZED METHODS OF COMMUNICATION (Check all that apply)			
☐ ***Residence Telephone***	☐ ***Work Telephone***	☐ ***Written Correspondence***	***Other (Specify)***
Number: ( )	Number: ( )	☐ Mail/Delivery Service	
☐ Leave call back number only; do not leave message	☐ Leave call back number only; do not leave message	☐ Fax:	
☐ Okay to leave detailed message with person	☐ Okay to leave detailed message with operator	☐ Email @ Residence:	
☐ Okay to leave detailed message on answering machine	☐ Okay to leave detailed message on personal voice mail	☐ Email @ Work:	

Patient Signature:______________________________Date:______________

RECORD OF DISCLOSURES					
Date of Disclosure	Disclosed to: Name & Address or Contact Number	Description of PHI Disclosed and Purpose of Disclosure	Type of Disclosure *Enter T, P, or O	Person Disclosing	Method of Disclosure **Enter M, P, F, E, or OT

*T = Treatment, P = Payment, O = Health Care Operations Activities
**M = Mail, P = Telephone, F = Fax, E = E-Mail, OT = Other (and specify mode of delivery)