

**DISCLOSURE OF PROTECTED HEALTH INFORMATION**  
**RETURN THIS FORM TO: HIM/Medical Records**

Complete **all** questions –

1. Patient Name and MRN or affix patient label:

2. Date of Disclosure \_\_\_\_\_

3. Name of the entity or person who received the protected health information and address/contact information of such entity or person:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Brief description of protected health information disclosed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Account for all information released. Use back of form if additional space is needed)

5. Purpose of the disclosure that reasonably informs the individual of the basis for the disclosure:

Mandatory report -- specify:

\_\_\_\_\_  
\_\_\_\_\_

Other – specify:

\_\_\_\_\_  
\_\_\_\_\_

Name of person making disclosure:

\_\_\_\_\_  
**Print name**

\_\_\_\_\_  
**Signature**