



INSTRUCTIONS: Please complete this form for each disclosure of Protected Health Information (PHI) to anyone other than a HCHD workforce member when the patient's (or his/her representative) authorization is not obtained or provided. See HCHD Policy 3.11.306 *Permitted Use and Disclosure of Protected Health Information Without Patient's Authorization*

PRINT LEGIBLY

1. Patient Name:	
2. Medical Record Number:	
3. Date of Disclosure:	
4. Name of person or entity receiving PHI: Include the address and telephone number if known	
5. Brief Description of PHI disclosed: Check all that apply	<input type="checkbox"/> Demographic information (name, address, telephone, contact, etc...) <input type="checkbox"/> Procedure <input type="checkbox"/> Date(s) of Service: _____ <input type="checkbox"/> Diagnosis <input type="checkbox"/> Diagnostic results, Specify: _____ <input type="checkbox"/> History/ consult/ physical examination <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency record of treatment <input type="checkbox"/> Itemized bill or billing information <input type="checkbox"/> Entire Medical/clinical record <input type="checkbox"/> Designated Record Set <input type="checkbox"/> Other, specify: _____
6. Purpose of the disclosure: Check all that apply	<input type="checkbox"/> Federal & state law; local ordinances <ul style="list-style-type: none"> <input type="checkbox"/> Child/Adult Protective Services <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other, specify, _____ <input type="checkbox"/> Funeral Homes/ Medical Examiner/ Coroner <input type="checkbox"/> Organ/ Tissue Procurement <input type="checkbox"/> Public Health <ul style="list-style-type: none"> <input type="checkbox"/> Registries/ Vital Statistics <input type="checkbox"/> FDA <input type="checkbox"/> Social Services <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Health Oversight <ul style="list-style-type: none"> <input type="checkbox"/> Certification/ Licensure (JCAHO, CARF, TDH, etc...) <input type="checkbox"/> Financial (TDH, CMS, auditors) <input type="checkbox"/> Military/ Veterans Affairs <input type="checkbox"/> Other, Specify: _____
<input type="checkbox"/> A written request for PHI is from someone other than the patient and is attached to this report	
7. Employee Name and ID (Who disclosed the PHI)	
8. Facility where disclosure occurred:	