

(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



### Disclosure Reporting Form

Instructions: This form is used to document patient disclosures that are subject to a patient's request for an "Accounting of Disclosures." Refer to "Accounting for Disclosures" policy. Fill out the information below and send the form to Slot 524.

Name of the person making the disclosure: \_\_\_\_\_

Location: \_\_\_\_\_ Phone # : \_\_\_\_\_

\* \* \* \* \*

Patient Name: \_\_\_\_\_  
*Last Name / First Name / MI*

Date of birth: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Brief description of the information disclosed.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of the disclosure: \_\_\_\_\_ (MM/DD/YYYY)

Brief statement of the purpose of the disclosure.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person or entity who received the information and address (if known).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person filling out this form, if different than above: \_\_\_\_\_



\_\_\_\_\_  
Signature Date Time