(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

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