Patient Record of Disclosures

_____ _____
Name Birthdate

I wish to be contacted in the following manner (check all that apply):

□ Home phone:_____
- □ OK to leave message with detailed information
- □ Leave message with call back number only

□ Work phone_____
- □ OK to leave message with detailed information
- □ Leave message with call back number only

□ Written Communication
- □ OK to mail to my home address
- □ OK to mail to my office/work address
- □ OK to fax to this number

□ other_____

_____ _____
Patient signature date

***** The section below is for the provider or doctor to fill out***

Record of Disclosures of Protected Health Information

Legend for table below:
- A = check box if the disclosure is authorized
- B = T=treatment records P=payment records O=healthcare Operations A=Authorization on file D=Discretionary
- C = How disclosure is made F=fax P=phone E=email M=mail O=other

Date	Disclose to whom/address/fax #	A	Description/Purpose of disclosure	By whom (provider)	B	C