

THE UNIVERSITY OF ARIZONA
TRACKING FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FOR INTERNAL USE ONLY

Instructions: Please complete this form for each disclosure of protected health information (PHI) to an outside person, entity or organization where the patient's written authorization was NOT obtained. Do NOT complete this form if the PHI was released for treatment, payment or health care operations. Please see HIPAA Policy and Procedure: Individual's Right to Request an Accounting of Disclosures for more information.

Name of UA Department or Clinic Making Disclosure

Address of UA Department or Clinic Making Disclosure

Patient Name

Billing Number

Name of Person or Entity Receiving PHI

Address and/or Other Contact Information of Person or Entity Receiving PHI

A written request for disclosure of the PHI was received from an individual other than the patient and is attached to this form.

Type(s) of PHI Disclosed (Check All That Apply):

- Demographic Information; such as name, address, telephone number or other contact data
- Diagnosis or procedure information Lab test results, specify: _____
- Radiology results, specify: _____ History or physical examination
- Discharge summary Consultation Entire medical record
- Emergency record of treatment Itemized bill or billing information
- Other, specify: _____

Please continue to page 2.

Purpose of Disclosure (check one):

- State or federal law required reporting (such as reporting births, deaths, communicable diseases, FDA, suspected abuse, crime victims and injuries)
- Organ donation or transplantation Medical examiner Funeral home Research
- Subpoena, court order, or other lawful process; see attached document
- Other, specify:

Name of Person Who Completed This Form

Title and Department Name

Telephone Number

Date (MM/DD/YYYY)