REPORT OF MANDATORY DISCLOSURE OF PHI

Patient Name _____

Preferred ID No: __ __ __ - __ __ - __ __ DOB _____

Address_____

City _____ State _____ Zip _____

Location: FCC Houston FCC Broadway FCC Glenwood FCC Jacksonville FCC Athens
Outpatient Clinic _____
(specify clinic/PCN)

Purpose of Release (please be as specific as possible)

Public Health/Infectious Disease Reporting_____

Disclosures About Victims of Abuse/Neglect or Domestic Violence _____

Uses and Disclosures to Avert a Serious Threat to Health or Safety_____

Other Mandatory or Required reporting: _____

Disclosed to:

Name of Organization:_____

Name of Individual (if applicable)_____

Address:_____

Phone Number:_____ Fax No:_____

Name of Person/Department Disclosing the PHI _____

Phone No. _____Pager No._____

Date Released:_____ Check if disclosed by fax:

☐ ***Copy of report (PHI) disclosed is attached*** ***<u>OR</u>*** ***Indicate PHI released:***

Description of PHI Disclosed	Date From	Date To	Notes

When you have completed this form, please return it to the designated FCC Clinic Front Office

Date received at FCC Front Office: _____