



**ACCOUNTING OF DISCLOSURES - DOWN TIME AND MANUAL TRACKING FORM**

<b>Patient Name:</b>	<b>Medical Record Number:</b>
<b>Name of Requestor:</b>	
<b>Attention:</b>	
<b>Requestor Address Line 1:</b>	
<b>Requestor Address Line 2:</b>	
<b>Requestor City:</b>	<b>Requestor State, Zip:</b>
<b>Purpose of Disclosure:</b> <input type="checkbox"/> Abuse/Neglct <input type="checkbox"/> Erroneous <input type="checkbox"/> Health OverS <input type="checkbox"/> Oth Disease <input type="checkbox"/> Public Safety <input type="checkbox"/> Comm Disease <input type="checkbox"/> FDA Report <input type="checkbox"/> Legal ProceS <input type="checkbox"/> Other <input type="checkbox"/> Research <input type="checkbox"/> Coroner <input type="checkbox"/> Funeral Dir <input type="checkbox"/> Military <input type="checkbox"/> Police <input type="checkbox"/> Workers Comp <input type="checkbox"/> Court <input type="checkbox"/> Gov Prot Svc <input type="checkbox"/> Organ Procur <input type="checkbox"/> Public Health <input type="checkbox"/> Wound-Injury <input type="checkbox"/> Employer	
<b>Information Disclosed:</b>	
<b>Date of Disclosure:</b>	<b>Method of Delivery:</b> <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other <input type="checkbox"/> Phone <input type="checkbox"/> Verbal <input type="checkbox"/> Walk-in
<b>Disclosed By:</b>	

**Key for Accounting for Disclosures Tracking Form**

Patient Name:	Name of the patient for which the PHI is being disclosed.
Medical Record Number:	Medical record number of the patient for which PHI is being disclosed.
Requestor:	Name of entity or person requesting information to be disclosed or released.
Attention:	Name of specific person intended to receive disclosed/released PHI information.
Requestor Address Line 1:	Street name and number of the entity or person requesting information to be disclosed or released.
Requestor Address Line 2:	Additional address line (i.e. suite number, P.O. Box).
Requestor City:	City of the entity or person requesting information to be disclosed or released.
Requestor State, Zip:	State and zip of the entity or person requesting information to be disclosed or released.
Purpose of Disclosure:	Brief description of the purpose of the disclosure to reasonably inform the individual of the basis of the disclosure. Please check appropriate entity provided in the purpose of disclosure section.
Information Disclosed:	Description of items and types of information disclosed or released.
Date of Disclosure:	Date the information was disclosed or released.
Method of Delivery:	The method used to disclose or release the information. Please refer to medical center policies regarding fax and electronic communication.
Disclosed By:	Actual person disclosing or releasing PHI information.

THIS FORM SHOULD BE USED TO FACILITATE LOGGING OF DISCLOSURES WHEN THE DISCLOSURE TRAC SYSTEM IS DOWN OR DOCUMENT DISCLOSURES UNTIL THE INFORMATION CAN BE ENTERED INTO THE DISCLOSURE TRAC SYSTEM BY THE UCMC LOCATION/DEPARTMENT THAT MADE THE DISCLOSURE.