PHI DISCLOSURE FORM

Who's PHI was disclosed:

Name: (First/Middle/Last) _____

Address: (Street/City/Sate/Zip code) _____

_____

Date of Birth: _____ *Social Security/Client number:*_____

Disclosure Information:

Date of Disclosure: _____

Is there a Valid Authorization to Release PHI in place? ☐ Yes ☐ No

Is there a Valid Authorization to Release PHI in place? ☐ Yes ☐ No

If 'No': ☐ Letter Sent to Client to obtain Authorization (if appropriate)

- Date Sent _____ - Date Obtained _____

☐ Letter of Denial , No valid Authorization, sent (if appropriate) - Date: _____

Name of person or entity who received the PHI: _____

Address of person or entity who received the PHI: _____

_____

Describe the PHI that was disclosed: _____

_____

Reason PHI was disclosed: _____

_____

Name of employee handling disclosure of the PHI: _____

MINIMUM NECESSARY:

☐ The MINIMUM necessary requirement does not apply to this disclosure because:

- ☐ Disclosure was made to the individual or to his/her personal representative
- ☐ Disclosure was made pursuant to an authorization executed by the individual or to the individual's personal representative (attach copy of authorization)
- ☐ Disclosure was made to a professional pursuant to our privacy practices
- ☐ Disclosure was made for documented research purposes
- ☐ Disclosure was made to a health care provider for treatment purposes
- ☐ Disclosure was made to the Dept. of Health & Human Services for compliance requirements
- ☐ Disclosure was made to a health care provider for treatment purposes
- ☐ Disclosure was made pursuant to Iowa Code § _____
- ☐ Disclosure was made to be in compliance with the HIPAA Administration Simplification Rules. Pursuant to Rule# _____

☐ The Disclosure was made in accordance with our privacy practices and was limited to the minimum necessary to accomplish the purpose for which the request is made.