

# PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE LOG

Patient Name:

Medical Record #:

Date Of Birth: MM / DD / YY

Other Identifier (Social Security Number):

Date Request Received	Name Of Person Or Entity Requesting Disclosure	Address	Reason For Request To Disclose	PHI Disclosed	Information Released By: (Name)

RETAIN IN PATIENT RECORD

FOR SECURITY PURPOSES THIS DOCUMENT HAS A COLORED BACKGROUND TO PREVENT UNAUTHORIZED DUPLICATION.

Form 104  
©2003