



Facility Name, Address, Phone #, Fax #

**RECORD OF ACCESS/DISCLOSURE/RELEASE OF PERSONAL HEALTH INFORMATION  
(COMMUNITY) FORM**

To: \_\_\_\_\_ From: \_\_\_\_\_  
 Fax #: \_\_\_\_\_ Date: \_\_\_\_\_  
 Phone# \_\_\_\_\_ Pages: \_\_\_\_\_ (including this cover page)

Client Name: \_\_\_\_\_ Health Record # \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ (dd/mmm/yy)

Reason for Disclosure:  Transfer  Referral  Other \_\_\_\_\_

Information Disclosed by:  Fax  Mail  Sent with Client  Other \_\_\_\_\_

**INFORMATION DISCLOSED (Check all that apply and include applicable dates/timeframes of reports(s) disclosed):**

Date of Report	Date of Report
<input type="checkbox"/> Assessment _____	<input type="checkbox"/> Consult Record _____
<input type="checkbox"/> Discharge Summary _____	<input type="checkbox"/> Immunizations _____
<input type="checkbox"/> Letter _____	<input type="checkbox"/> Memo _____
<input type="checkbox"/> Progress Note _____	<input type="checkbox"/> Referrals _____
<input type="checkbox"/> Other _____	

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