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**
☐ Assessment	_____	☐ Consult Record	_____
☐ Discharge Summary	_____	☐ Immunizations	_____
☐ Letter	_____	☐ Memo	_____
☐ Progress Note	_____	☐ Referrals	_____

☐ Other _____