



Facility Name, Address, Phone #, Fax #

**RECORD OF ACCESS DISCLOSURE/RELEASE OF PERSONAL HEALTH INFORMATION**

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 report(s) disclosed):**

**Date of Report**

**Date of Report**

Consultation Report \_\_\_\_\_

Other Prenatal Record \_\_\_\_\_

Discharge Summary \_\_\_\_\_

Pathology Report \_\_\_\_\_

ED/OPD Record \_\_\_\_\_

Other \_\_\_\_\_

History & Physical \_\_\_\_\_

\_\_\_\_\_

Operative Report \_\_\_\_\_

\_\_\_\_\_

Referral Letter \_\_\_\_\_

\_\_\_\_\_

**DIAGNOSTIC IMAGING**

**DIAGNOSTICS**

CT Scan \_\_\_\_\_

Chemistry \_\_\_\_\_

MRI \_\_\_\_\_

EKG \_\_\_\_\_

Ultrasound \_\_\_\_\_

Hematology \_\_\_\_\_

X-ray \_\_\_\_\_

Microbiology \_\_\_\_\_

Mammogram \_\_\_\_\_

Urinalysis \_\_\_\_\_

Other \_\_\_\_\_

FOBT \_\_\_\_\_

Urine C&S \_\_\_\_\_

Other \_\_\_\_\_

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