



PATIENT I.D. DATA:
(Name, DOC#, DOB)

HEALTH INFORMATION DISCLOSURE

RELEASED BY (DOC EMPLOYEE/CONTRACT STAFF NAME/TITLE)	DATE	TIME	REFERENCE #
RELEASE TO (REQUESTER'S NAME/TITLE)			
REQUESTER'S ADDRESS		REQUESTER'S TELEPHONE	

Reason health information was reviewed/released:

If health information was released via copies/fax, state inclusive dates, consultations, reports, etc.:

If health information was verbally released, state what information was provided:

Health information was release by (check as applicable):

- Copies
 Fax
 Review
 Scan/E-mail
 Telephone
 Verbal

SIGNATURE – CHECK APPROPRIATE BOX: Signature and stamp of person disclosing information
 Signature of patient receiving information

DATE

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.