Wee Care Pediatrics

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Protected Health Information (PHI) Disclosure Record

Patient Name:_____________________________ DOB _____/_____/_____

Authorized Methods of Communication (✓ Check all that apply)

☐ Residence Phone	☐ Work Phone	☐ Written Correspondence	☐ Other (Specify)
Number ( )	Number ( )	Number ( )	
☐ Leave call back number Do not leave message	☐ Leave call back number only; do not leave message	☐ Mail/Delivery Service ☐ Fax ( )	
☐ Okay to leave detailed message with person	☐ Okay to leave detailed message with operator	☐ Email @ Residence	
☐ Okay to leave detailed message on answering machine	☐ Okay to leave detailed message on personal voice mail	☐ Email @ Work	

Parent/Guardian Signature____ Date___________

Record of Disclosures

Date of Disclosure	Disclosed to Name & Address or Contact Number	Description of PHI Disclosed and Purpose of Disclosure (If a copy of the authorization or request is attached, check the box below.)	Type of Disclosure Enter T, P, or O	Person Disclosing	Method of Disclosure **Enter M, P, F, E, or OT
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*T=Treatment, P=Payment, O=Health Care Operations Activities
**M=Mail, P=Telephone, F=Fax, E=E-Mail, OT=Other(and specify mode of deliver)