ResCare

Attachment A
ACCOUNTING FOR DISCLOSURES FORM
(PHI Documentation)

Instructions: Please complete this form for each disclosure of client protected health information (PHI) to an outside person, entity or organization where the client's written authorization was not obtained. The form should not be completed if the release of PHI relates to continuing care/treatment, payment or health care operations. See ResCare HIPAA Policy 1.16 for additional guidance.

Client Name:		**Other client ID:**	
Date of Disclosure:			
Name of Person/Entity Receiving the PHI:		**Address of Person/Entity Receiving the PHI:**	
Was a Written Request for the PHI Received: Yes No *(If yes, attach the written request to this form)*			
Brief Description of PHI Disclosed: *(check all that apply)*	o Demographic information (name, address, telephone number) o Date of Birth o Medicaid number o Service Plan o Diagnosis o Lab test results _____ o Discharge Summary o Entire client file o Itemized bill or billing information o Other (*specify*):_____		
Brief Statement of Purpose of Disclosure:	o State or federal law required reporting, e.g. death, communicable disease, suspected abuse, crime victim, etc. o Medical examiner/coroner o Oversight agency (*specify*)_____ o Subpoena, Court Order or other lawful process *(attach document)* o Law enforcement purposes o Mistaken disclosure (*specify*)_____ o Other (*specify*)_____		

Person Completing Form:_____ Title:_____

Date Completed:_____

For Internal Use Only, Please File at Operation's Core Office