

ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION FORM

Resident Name:

Medical Record Number:

Date of Last Accounting:

Completed By:

Date of Disclosure	If Multiple Disclosures to single entity: Frequency?	Name of Recipient of Disclosed PHI	Address of Recipient of Disclosed PHI	Brief Description of PHI Disclosed	Purpose of Disclosure

In lieu of this, you may attach copy of an individual authorization, copy of individual's request for disclosure, or copy of request for disclosure not requiring authorization.