UCR Health
Report of Mandatory Disclosures of PHI

Patient Name: _____
Medical Record Number: _____ DOB: _____

Disclosing Department/Practice: _____
Name of Staff Making Disclosure: _____
Date Released: _____

Purpose of Release

☐ Public Health/Infectious Disease Reporting
☐ Disclosures Regarding Victim of Abuse/Neglect or Domestic Violence
☐ Use and Disclosure to Avert Serious Threat to Health or Safety
☐ Other: _____

Disclosed to:

Name of Organization: _____
Name of Individual: _____
Address: _____
Phone Number: _____ Fax. No.: _____

☐ Copy of Report (PHI) attached OR:

Description of PHI Disclosed	Date From	Date To	Notes

***Forward to*: University of California Riverside Health Correspondence, Health Information Management Department, 900 University Avenue, Riverside, California 92521.**