

Improper Disclosure Form

If you accidentally disclosed protected health information (PHI), please complete the following form and return it to Professor Peter Jacobson.

Name _____ **Date of Disclosure** _____

Department _____ **Position** _____

Phone _____ **Email** _____

What PHI was disclosed?

- | | |
|--|---|
| <input type="checkbox"/> Names | <input type="checkbox"/> License Numbers |
| <input type="checkbox"/> Addresses | <input type="checkbox"/> Vehicle Identification Numbers |
| <input type="checkbox"/> All Dates | <input type="checkbox"/> Account Numbers |
| <input type="checkbox"/> Telephone & Fax | <input type="checkbox"/> Biometric Identifiers |
| <input type="checkbox"/> Email Addresses | <input type="checkbox"/> Device Identifiers |
| <input type="checkbox"/> Social Security Numbers | <input type="checkbox"/> Full Face Photos |
| <input type="checkbox"/> Medical Record Numbers | <input type="checkbox"/> Any Other Unique Identifying |
| <input type="checkbox"/> Health Plan Numbers | <input type="checkbox"/> Number, Characteristic or Code |

Disclosure of PHI through: _____ paper _____ Internet/email _____ verbal

Description of where and how relevant PHI was disclosed:

Was the disclosed PHI recovered? _____ Yes _____ No