SPECTRUM HEALTH

Patient Name	
DOB	
MRN	
Physician	
FIN	

Authorization
MEDICAL RECORDS DISCLOSURE LOG HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

BEFORE DISCLOSING PERSONAL HEALTH INFORMATION

1) Verify the identity of individual requesting information and the purpose for the disclosure.
2) Note any specifications from patient regarding the release of their Personal Health Information (Restrictions, Authorizations, Designations).
3) Document any non-routine disclosures of health information **EXCEPT**:
   - To carry out treatment, payment, health care operations.
   - To persons or representatives involved in the individual's care
   - Pursuant to an authorization

Note: See disclosure guide for requirements for other types of disclosures

RESTRICTIONS ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RESTRICTIONS

Note: Restriction/Communication requests must be approved by physician and/or manager. Request form should be placed in medical record.

DESIGNATION OF PERSONS INVOLVED IN CARE

NAME	PHONE	RELATIONSHIP TO PATIENT	PATIENT SIGNATURE	DATE

Note: Patient signature authorizes Spectrum Health to disclose personal health information to the designated individuals.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

OVER ➔

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

DISCLOSURE LOG

DATE	INFORMATION DISCLOSED	PURPOSE OF DISCLOSURE INFORMATION	RECIPIENT OF INITIALS	STAFF

STAFF SIGNATURE	INITIALS	STAFF SIGNATURE	INITIALS

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.