UCLA HEALTHCARE

REPORT OF MANDATORY DISCLOSURE OF PHI

Patient Name _____

Preferred ID No: __ __ __ - __ __ - __ __ DOB _____

Address_____

City _____ State _____ Zip _____

Location: WWH SMH NPH
Outpatient Clinic/ Primary Care Network Clinic _____
(specify clinic/PCN)

Purpose of Release (please be as specific as possible)

- ❑ Public Health/Infectious Disease Reporting_____
- ❑ Disclosures About Victims of Abuse/Neglect or Domestic Violence _____
- ❑ Uses and Disclosures to Avert a Serious Threat to Health or Safety_____
- ❑ Other Mandatory or Required reporting: _____

Disclosed to:

Name of Organization:_____

Name of Individual (if applicable)_____

Address:_____

Phone Number:_____ Fax No:_____

Name of Person/Department Disclosing the PHI _____

Phone No. _____Pager No._____

Date Released:_____ Check if disclosed by fax:

❑ ***Copy of report (PHI) disclosed is attached OR Indicate PHI released:***

Description of PHI Disclosed	Date From	Date To	Notes

(Forward to the Privacy Management Office, UCLA Healthcare, 10833 Le Conte Avenue, Room CHS BH-265 Los Angeles, CA 90095-7305 or Fax to 310-206-2820)