Disclosure Notice—Third Party
Hillsborough County
Notice of Disclosure of Protected Health Information to Third Party

Directions: This form is to be used to inform an individual of the disclosure of his or her protected health information. Its contents should be entered into the HIPAA compliance system by your Privacy Liaison. The form should also be filed with the patient's records.

Notice date: _____

Patient's full name: _____ ___ _____ _____
First MI Last Suffix

SSN or other patient identifier: _____

Name of third party: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Fax: _____

Authorization: _____ Identification: _____

Reason or Purpose of Disclosure:

- ❑ Required by law
- ❑ Public health activities
- ❑ Victims of abuse, neglect, or domestic violence
- ❑ Health oversight activities
- ❑ Judicial and administrative proceedings
- ❑ Law enforcement purposes
- ❑ Decedents
- ❑ Cadaveric organ, eye, or tissue donation purposes
- ❑ Research purposes
- ❑ Avert a serious threat to health or safety
- ❑ Specialized government functions
- ❑ Workers' compensation
- ❑ Personal representative
- ❑ Other third party: _____

Original signature of recipient: _____

Printed name: _____ Request date: _____

Original signature of staff providing the information: _____

Printed name: _____ Disclosure date: _____

NOTES: _____