



Disclosure/Privacy Action Recording Form
HIPAA Privacy Action
Recording Form
Hillsborough County

Directions: This form is to be used to track privacy actions and disclosures of protected health information (PHI) subject to tracking under the HIPAA Privacy Rule. Disclosures of PHI to the patient do not need to be tracked. Disclosures of PHI for treatment, payment, or health care operations do not need to be tracked. Consult the HIPAA Privacy and Security Policies and Procedures and training materials for more information. If you have questions, contact the HIPAA Compliance Officer at (813) 276-2343. When complete, keep a copy for your records, and send the original of each HIPAA Privacy Action recording form to the Privacy Office for filing.

Requestor's Name				
	First	MI	Last	Suffix
Address				
Phone				
Relationship or Office Authority Verified?				

Date of request for action: _____

Type of action being recorded (Indicate one):

Request for access to PHI by someone other than the patient	Request to revoke a previously given authorization	Complaint about County Privacy action or practice
Request by the patient to designate a personal representative	Request by the patient or representative to restrict access to information	Request for alternate method of communication
Request to cancel designation of personal representative	Request to amend PHI held by the County	Request by the patient or representative for an accounting of disclosures
Request by the patient or representative to authorize access to information	Appeal of a previous privacy decision	

This pertains to the following individual (plan member or patient of the county):

Individual's Name				
	First	MI	Last	Suffix
Address				
Phone				
Email				
Patient ID				

If disclosure is being made to someone who is not the patient, list the individual who is to receive the disclosure. (If a personal representative, attach documentation to indicate how the relationship was verified.)

If disclosure is being given to someone that is not the patient and not the designated personal representative of the patient, check one of the boxes below. Identify the data released. Make sure you do not release any data not specifically requested or authorized. Attach documentation, such as a copy of the request or subpoena, if applicable.

<input type="checkbox"/>	Law Enforcement
<input type="checkbox"/>	Public Health Official
<input type="checkbox"/>	Military Personnel
<input type="checkbox"/>	Public Safety Official
<input type="checkbox"/>	Court Order or Subpoena
<input type="checkbox"/>	Research

Verification of Identity and Authority. Describe briefly how identity of the requestor and his/her authority were verified:

Describe what data was released:

Briefly describe the request and its purpose:

Effective dates: Begin: _____ End: _____

Did you take the action requested? (Check one)

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (Why not? Describe reason for denial)
<input type="checkbox"/>	Partially (Describe)

Date of action: _____

Name of Hillsborough County Staff Recording Action: _____

Original Signature of
Hillsborough County Staff Recording Action: _____

<i>For internal use only:</i> Date Received: _____ Recipient: _____
