CATHOLIC
Medical
CENTER

PATIENT INFORMATION DISCLOSURE FORM

PATIENT NAME:_____ DATE OF BIRTH:_____

DATE OF DISCLOSURE:_____ MEDICAL RECORD#_____

DISCLOSURE TO:_____

ADDRESS, If known:_____

PURPOSE:
- ☐ INFECTIOUS/ COMMUNICABLE DISEASE REPORTING
- ☐ ABUSE OR NEGLECT REPORTING
- ☐ SEXUAL ASSAULT REPORTING
- ☐ GUNSHOT/ STABBING REPORTING
- ☐ OTHER: _____

DATE(S) OF SERVICE: _____

INFORMATION DISCLOSED

☐ **DIAGNOSIS**	☐ **ENTIRE ENCOUNTER**	☐ **ENTIRE RECORD**
☐ **DISCHARGE SUMMARY**	☐ **H&P**	☐ **OPERATIVE REPORT**
☐ **PT DEMOGRAPHICS**	☐ **CONSULT REPORT**	☐ **PROGRESS NOTES**
☐ **LAB RESULTS**	☐ **TREATMENT INFORMATION**	☐ **RADIOLOGY REPORTS**
☐ **OTHER SPECIFY:**		

Comments:

_____
_____
_____
_____
_____

**FORWARD THIS COMPLETED FORM TO THE MEDICAL RECORDS

DEPARTMENT FOR FILING IN THE PATIENT'S RECORD**