

Iowa Department of Human Services

**RECORD OF DISCLOSURE OF HEALTH INFORMATION**

Name of Client	State ID												
Social Security Number (Medicaid or <i>hawk-i</i> )	Client ID (facilities)												
Date of Birth	Parent/Guardian (if applicable)												
Name of Person or Entity Receiving Information	Date of Disclosure												
Address of Person or Entity – Street or P.O. Box	City, State, and Zip Code												
<p>Check purpose for the disclosure and provide a brief explanation of purpose checked or attach copy of written request for disclosure.</p> <table> <tr> <td><input type="checkbox"/> Health oversight activities</td> <td><input type="checkbox"/> Victims of abuse, neglect or domestic violence</td> </tr> <tr> <td><input type="checkbox"/> Judicial and administrative proceedings</td> <td><input type="checkbox"/> About decedents</td> </tr> <tr> <td><input type="checkbox"/> Law enforcement purposes</td> <td><input type="checkbox"/> For cadaveric organ, eye, or tissue donation</td> </tr> <tr> <td><input type="checkbox"/> To avert a threat to health or safety</td> <td><input type="checkbox"/> For specialized government functions</td> </tr> <tr> <td><input type="checkbox"/> Required by law</td> <td><input type="checkbox"/> By whistleblowers</td> </tr> <tr> <td><input type="checkbox"/> For public health activities</td> <td><input type="checkbox"/> Accidental disclosures</td> </tr> </table> <p>Explanation:</p>		<input type="checkbox"/> Health oversight activities	<input type="checkbox"/> Victims of abuse, neglect or domestic violence	<input type="checkbox"/> Judicial and administrative proceedings	<input type="checkbox"/> About decedents	<input type="checkbox"/> Law enforcement purposes	<input type="checkbox"/> For cadaveric organ, eye, or tissue donation	<input type="checkbox"/> To avert a threat to health or safety	<input type="checkbox"/> For specialized government functions	<input type="checkbox"/> Required by law	<input type="checkbox"/> By whistleblowers	<input type="checkbox"/> For public health activities	<input type="checkbox"/> Accidental disclosures
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<p>Brief description of the protected health information disclosed:</p>													
Signature of Person Making the Disclosure	Date												