Iowa Department of Human Services

Record of Disclosure of Health Information

Name of Client	State ID
Social Security Number (Medicaid or *hawk-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

Check purpose for the disclosure and provide a brief explanation of purpose checked or attach copy of written request for disclosure.

- ☐ Health oversight activities
- ☐ Judicial and administrative proceedings
- ☐ Law enforcement purposes
- ☐ To avert a threat to health or safety
- ☐ Required by law
- ☐ For public health activities
- ☐ Victims of abuse, neglect or domestic violence
- ☐ About decedents
- ☐ For cadaveric organ, eye, or tissue donation
- ☐ For specialized government functions
- ☐ By whistleblowers
- ☐ Accidental disclosures

Explanation:

Brief description of the protected health information disclosed:

Signature of Person Making the Disclosure	Date