LOUISIANA DEPARTMENT OF HEALTH

Disclosures Tracking Form

Individual's Name: (Last, First, MI)	Medicaid ID # or Social Security #:

Use this form for disclosures made without a signed authorization form. A copy of this form may be provided to the individual requesting an accounting of disclosures made by your office.

Date Request Received	Requestor's Name, Address, Phone #	Purpose of Disclosure *(i.e .audit review, law enforcement, public health, research)*	PHI/Information Disclosed	Date Disclosed	Disclosed By

Request for Accounting of Disclosures

Use this section to document accounting requests when a copy of this disclosure tracking form is provided to the individual requesting the accounting.

Requested By *Indiv/Per Rep*	Date Requested	Date Range Requested *(After 4/13/03)*	Request Completed By *(Name & Title)*	Date & Method *(mail, e-mail, fax)*