**Incomplete Request**

UW Medicine Entity

Address

Date:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Individual,

The UW Medicine has received a request to disclose your protected health information, BUT we cannot proceed because the form is incomplete.

Please fill out the attached **AUTHORIZATION FOR UW MEDICINE TO DISCLOSE PROTECTED HEALTH INFORMATION** or complete the areas that have been highlighted and return it to us so that we can carry out the request.

If you have questions or if you need assistance, you may contact the entity’s Release of Information Manager/Supervisor at XXX. xxx.xxxx. These numbers need to be entity specific.

Sincerely,

*Name*

*Title*

*Phone Number*