**Date Sent to Compliance\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Entity:**

HARBORVIEW MEDICAL CENTER  HALL HEALTH  NWH  OTHER:

UNIVERSITY OF WA MEDICAL CENTER  NEIGHBORHOOD CLINICS  VMC \_\_\_\_\_\_\_\_\_\_\_\_

**Department**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Reporting Disclosure**:

**Date of Disclosure (may be DOS):** \_\_\_\_\_\_\_\_\_\_\_ **Date of Discovery (date returned):** \_\_\_\_\_\_\_\_\_

**What Happened? Brief description:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Record Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Document Type:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Listen to dictation and write exactly what was dictated: Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **or  No address dictated**

**If provider moved, did patient follow provider?  Yes  No  N/A**

**Was the information:**

**Returned Unopened**

**Returned Opened**

**Deleted**

**Destroyed**

**Location:**

**Email**

**Misdirected Mail**

**Paper (other)**

**Computer**

**Portable device**

**Improper Disposal**

**Unauthorized Access**

**Loss**

**Who Transcribed Document:**

* **UWMC/HMC/UWNC/HH Transcriptionist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **TSI/Precyse Transcriptionist**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Other (anyone else modifying document)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTION TAKEN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Mail completed form and a copy of all document(s) disclosed to*** [***comply@uw.edu***](mailto:comply@uw.edu) ***or to the Privacy Program at Box 359210***