FAX

Date: _____ Time: _____

To: _____ Facility: _____

Fax: _____

From: _____ Facility: _____

Fax: _____

Pages: _____

Patient Information:

Name: _____ DOB: _____

MRN: _____

Purpose of Disclosure:

☐ Treatment ☐ Payment ☐ Healthcare Operations

☐ Other: _____

Message:

_____

This fax contains Protected Health Information (PHI). Unauthorized use or disclosure is prohibited under HIPAA.