



LOS ANGELES COUNTY
**DEPARTMENT OF
MENTAL HEALTH**
hope. recovery. wellbeing.

**COMPLIANCE, PRIVACY AND AUDIT SERVICES
HIPAA PRIVACY UNIT**

PROTECTED HEALTH INFORMATION/CONFIDENTIAL DATA FAX COVER SHEET

FAX DETAILS

Date Transmitted: _____ Time Transmitted: _____

Number of Pages (including cover sheet): _____

Intended Recipient: _____

TO

Name: _____

Facility: _____

Address: _____
(Address, City, State, Zip Code)

Telephone #: _____

Fax #: _____

FROM

Name: _____

Facility: _____

Address: _____
(Address, City, State, Zip Code)

Telephone #: _____

Fax #: _____

Document being faxed:

☐ Clinical Records

☐ Other: _____

CONFIDENTIALITY STATEMENT

This facsimile transmission may contain Protected Health Information (PHI) and/or Confidential Data that is intended only for the use of the person or entity named above. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use or distribution of this information is strictly prohibited. In addition, there are federal, civil, and criminal penalties for the misuse or inappropriate disclosure of client PHI. If you have received the transmission in error, please notify contact person immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.

VERIFICATION OF TRANSMISSION OF PHI

Please contact _____ at _____ to verify receipt of this Fax or to report problems with the transmission.