

# FAX COVER FOR TRANSMITTING PHI

## FAX DETAILS

Date Transmitted: \_\_\_\_\_

Time Transmitted: \_\_\_\_\_

Number of Pages (including cover sheet): \_\_\_\_\_

Intended Recipient: \_\_\_\_\_

### TO

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

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

### FROM

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

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Documents being faxed:

Clinical Records

Other: \_\_\_\_\_

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This facsimile transmission may contain information that is privileged and confidential and 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 confidential patient information. If you have received this transmission in error, please notify the contact person listed below immediately by telephone to arrange for the return of the transmitted documents 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.

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I verify the receiver of this Fax has confirmed its transmission:

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_