

**Polk County Board of County Commissioners  
Disclosure of Protected Health Information  
Pertaining to Abuse, Neglect or Domestic Violence**

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

Please provide the name, title, organization name, and contact phone number of the person accepting the disclosure:

Patient's full name:

SSN or other patient identifier:

**This disclosure of protected health information is:**

- In regard to a child that Polk County believes may be the victim of abuse or neglect. The recipient of this information is authorized by law to receive such reports.
  
- In regard to an adult that Polk County believes may be the victim of abuse, neglect or domestic violence. The recipient of this information is authorized by law to receive such reports; and
  - The victim has given permission to Polk County to disclose the information for this purpose; or
  - The disclosure is required by law and will be made in a manner that is consistent with the law; or
  - Disclosing information for this purpose is expressly authorized by statute or regulation; and
    - Polk County believes that disclosing the information is necessary to prevent serious harm to someone; or
    - The victim is incapacitated and the official who is authorized to receive this report does not intend to use it against the victim. That official also stated that immediate law enforcement activity depends upon this information and such activity will be adversely affected without it.

If a written version of the disclosure exists, it is attached.

Signature of recipient: \_\_\_\_\_

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

Signature of Polk County staff providing the information:

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

**Polk County Board of County Commissioners  
Notice of Disclosure of Protected Health Information  
Pertaining to Abuse, Neglect or Domestic Violence**

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*Add this page only if appropriate.*

Polk County has reported to the proper authorities evidence of abuse, neglect or domestic violence. Polk County believes that the patient will not be harmed from knowing that Polk County reported the above information or, if Polk County is providing this notice to the patient's representative, that the patient's representative is not responsible for the abuse, neglect or injury. Therefore, Polk County hereby notifies the patient or his or her representative that such a disclosure has been made.

Patient's Full Name:

SSN or Other Patient Identifier:

Signature of Patient/Representative:

Date:

Signature of Polk County staff providing the information:

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