Patient Interview Transcript De-Identification Form

Reviewer Name

Date

Transcript Information

Transcript ID / Reference

Patient ID / Initials

De-Identified Fields Checked

- Name(s)
- Date of birth / Age
- Address
- Phone number
- Email
- Medical record / Patient number
- Health plan number
- Other direct identifiers

Other fields (specify)

Notes / Details of De-Identification

Specify methods used and any issues identified during de-identification:

Final Review

Reviewer Confirmation / Comments