UCONN HEALTH

HIPAA Privacy Incident Report

Instructions: This form is for use with all incidents. **REPORT KNOWN OR SUSPECTED PRIVACY INCIDENTS USING THIS FORM WITHIN 8 HOURS.** The form should be completed in its entirety. If more space is needed, please use a Word document and attach to this submission. **This report has 3 pages of data that should not take you longer than 10 minutes to complete.**

Reporter Information	**Date/Location Information**
Name (full):	**Today's Date:**
Phone Number:	**Department Responsible for Incident:**
Person Responsible for Incident: SELECT ONE	**Incident Date:** **Discovery Date:**
Responsible Department Manager:	**Manager Phone Number:**

Incident Description
Type of Incident: SELECT ONE
Describe specific incident details and actions taken:

Patients/Individuals Affected	
Total Number:	**Type:** SELECT ONE IF APPLICABLE
Names and MRN Numbers:	

Identifiers Involved

Check all that apply:

- ☐ Address
- ☐ Biometric Identifiers (e.g. fingerprint)
- ☐ Computer IP address
- ☐ Credit Card Number or other financial info
- ☐ Date of Service
- ☐ Device Identification or Serial Number
- ☐ DOB
- ☐ Driver's License Number
- ☐ Email address
- ☐ Fax Number
- ☐ Insurance Number(s)
- ☐ Lab results
- ☐ Location of Service
- ☐ Medications
- ☐ MRN
- ☐ Name
- ☐ Photo
- ☐ Provider Name
- ☐ SSN
- ☐ Telephone Number
- ☐ Zip Code
- ☐ Other (describe)

Clinical Information Involved

☐ Sensitive (e.g. mental health, infectious disease, sexual, cancer, genetics)
☐ Non-Sensitive (e.g. common medical illnesses)

Describe:

Person Who You Believe Inappropriately has the PHI

Check all that apply and provide names/contact information for each:

☐ Internal Workforce

Name:

Contact Info:

☐ Another HIPAA covered entity

Name:

Contact Info:

☐ Contractor or vendor

Name:

Contact Info:

☐ Another UConn Health patient(s)

Name

MRN#:

Is this patient also a UConn Health Employee: ☐ Yes ☐ No

☐ General public/member of community/business entity

Name:

Contact info:

☐ Patient's Employer

Name:

Contact info:

☐ Patient's family member or friend

Name:

Contact info:

☐ Other (please specify)

☐ Recipient unknown

Potential for Re-Identification
Check all that apply and provide names/contact information for each: ☐ Recipient personally knows the patient. Describe: ☐ Patient is well-known or a public figure. ☐ PHI is related to a publicized accident/event/unusual diagnosis Describe: ☐ PHI relates to a UConn Health employee/affiliate. ☐ Did the recipient obtain/receive the PHI? Describe: ☐ Did the recipient view the PHI? Describe:

Resolution of Incident	
Check all that apply: **Paper** ☐ Recipient confirms no further disclosure and has not printed, copied or shared the information ☐ Recipient attests to shredding of original document ☐ Recipient returns fax or paper to you at UConn Health If scanned and returned via email: ☐ Recipient agrees to destroy original document and delete all copies from email ☐ Recipient empties deleted items ☐ Recipient refuses to return or attest ☐ Manager of person responsible for incident notified **Verbal** ☐ Manager of person responsible for disclosure notified	**Electronic** ☐ Recipient confirms no further disclosure (has not shared, printed or copied the information) ☐ Recipient forwards email to you at UConn Health ☐ Recipient agrees to delete original email and the forwarded emails to you ☐ Recipient empties deleted items ☐ Recipient refuses to do above ☐ Manager of person responsible for incident notified ☐ (ePHI) secured ☐ System access controls in place **Disclosure Tracking Log Completed (see sample log)** ☐ Yes ☐ No **ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMAITON TO PATIENTS UPON THEIR REQUEST (Privacy & Security of Protected Health Information (PHI)) - POLICY NUMBER 2003-18**

Submit completed form to:

Office of Privacy Protection & Management

Email: privacyoffice@uchc.edu

PRINT FORM

SAVE FORM

EMAIL FORM