

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:	Incident Date: Discovery Date:
Responsible Department Manager:	Manager Phone Number:

Incident Description
Type of Incident:
Describe <u>specific</u> incident details and actions taken:

Patients/Individuals Affected	
Total Number:	Type:
Names and MRN Numbers:	

Identifiers Involved																						
<p>Check all that apply:</p> <table> <tr> <td>Address</td> <td>Lab results</td> </tr> <tr> <td>Biometric Identifiers (e.g. fingerprint)</td> <td>Location of Service</td> </tr> <tr> <td>Computer IP address</td> <td>Medications</td> </tr> <tr> <td>Credit Card Number or other financial info</td> <td>MRN</td> </tr> <tr> <td>Date of Service</td> <td>Name</td> </tr> <tr> <td>Device Identification or Serial Number</td> <td>Photo</td> </tr> <tr> <td>DOB</td> <td>Provider Name</td> </tr> <tr> <td>Driver's License Number</td> <td>SSN</td> </tr> <tr> <td>Email address</td> <td>Telephone Number</td> </tr> <tr> <td>Fax Number</td> <td>Zip Code</td> </tr> <tr> <td>Insurance Number(s)</td> <td>Other (describe)</td> </tr> </table>	Address	Lab results	Biometric Identifiers (e.g. fingerprint)	Location of Service	Computer IP address	Medications	Credit Card Number or other financial info	MRN	Date of Service	Name	Device Identification or Serial Number	Photo	DOB	Provider Name	Driver's License Number	SSN	Email address	Telephone Number	Fax Number	Zip Code	Insurance Number(s)	Other (describe)
Address	Lab results																					
Biometric Identifiers (e.g. fingerprint)	Location of Service																					
Computer IP address	Medications																					
Credit Card Number or other financial info	MRN																					
Date of Service	Name																					
Device Identification or Serial Number	Photo																					
DOB	Provider Name																					
Driver's License Number	SSN																					
Email address	Telephone Number																					
Fax Number	Zip Code																					
Insurance Number(s)	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 or 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 INFORMATION TO PATIENTS UPON THEIR REQUEST (Privacy & Security of Protected Health Information (PHI)) - POLICY NUMBER 2003-18

Submit completed form to:

The Office of Audit, Compliance and Ethics

Email: privacyoffice@uchc.edu