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: ○ UConn Health Employee ○ Non-UConn Health Employee	**Incident Date:**
Responsible Department Manager:	**Manager Phone Number:**

Incident Description

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 anyone view/obtain/receive the PHI?

  Describe:

Describe <u>specific</u> incident details and actions taken:

Patients/Individuals Whose PHI May Be Affected

Total Number:

Names and MRN Numbers:

Identifiers Involved

Check all that apply:

- ☐ Name
- ☐ Date of Birth
- ☐ Date of Treatment
- ☐ Address
- ☐ Telephone number
- ☐ Fax
- ☐ Email address
- ☐ URL address address
- ☐ IP address
- ☐ Social security number
- ☐ License numbers
- ☐ Account Number
- ☐ MRN (Medical record number)
- ☐ Health Plan Beneficiary number
- ☐ Device identifiers and their serial numbers
- ☐ Vehicle identifiers and serial numbers
- ☐ Biometric identifiers (finger and voice prints)
- ☐ Full face photos and other comparable images
- ☐ Any other unique identifying number, code or characteristics

Clinical/Financial Information Involved

☐ CLINICAL:
- ☐ Diagnosis/Condition
- ☐ Lab Results
- ☐ Medications
- ☐ Other Treatment Information

☐ FINANCIAL:
- ☐ Claims Information
- ☐ Credit Card/Bank Acct #
- ☐ Other Financial Information

☐ OTHER:
Type of Protected Health Information Involved (other)

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:
TA#:

☐ 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

Actions Taken to Date	
Check all that apply: **Paper:** ☐ Recipient confirmed no further disclosure and has not printed, copied or shared the information ☐ Recipient attested to shredding the original document ☐ Recipient returned paper to you at UConn Health via mail or hand delivered ☐ Recipient refused to return or attest ☐ Manager of person responsible for incident notified **Verbal** ☐ Manager of person responsible for disclosure notified	**Electronic** ☐ Recipient confirmed no further disclosure (has not shared, printed or copied the information) ☐ Recipient forwarded email to you at UConn Health ☐ Recipient agreed to delete original email and the forwarded emails to you ☐ Recipient emptied deleted items ☐ Recipient refused to do above ☐ Manager of person responsible for incident notified ☐ System access controls in place **Disclosure Tracking Log Completed (see policy)** ☐ 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:
The Office of Healthcare Compliance & Privacy
Email: privacyoffice@uchc.edu

PRINT FORM

SAVE FORM

EMAIL FORM