**HIPAA INCIDENT REPORT FORM**

**Date of Report**: [DATE]

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| **CONTACT PERSON** |

**Full Name**: [FULL NAME] **Title/Role**: [TITLE/ROLE]

**Phone**: [PHONE] **E-Mail**: [EMAIL]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

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| **INCIDENT DETAILS** |

**Date of Discovery**: [DATE OF INCIDENT] **Time**: [TIME]  AM  PM

**Actual Date of Incident** (if known): [DATE OF INCIDENT]

**How was the incident discovered?** [DESCRIBE DISCOVERY OF INCIDENT]

**Type of Information Disclosed**:  SSN  DOB  Address  Medical Information

Other: [OTHER]

**Describe the Incident**: [DESCRIBE THE INCIDENT]

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| **PERSONAL HEALTH INFORMATION (PHI)** |

**Do you know the identities of the Patients’ data that was involved?**  Yes  No

**If yes, how many records?** [#]

**Have the patients been contacted?**  Yes  No

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| **VIOLATOR INFORMATION** |

**Violator Name** (if known): [VIOLATOR NAME] **Title/Role** (if applicable): [TITLE/ROLE]

**Was the violation intentional?**  Yes  No

**Number of Prior Violations**: [#]

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| **CONTAINMENT** |

**Were any containment measures made?**  Yes  No

**If yes, describe**: [DESCRIBE CONTAINMENT MEASURES]

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| **IMPACTED SERVICES** |

**Were any services permanently impacted?**  Yes  No

**If yes, describe**: [DESCRIBE IMPACTED SERVICES]

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| **ACTIONS TAKEN** |

**Were any actions taken to prevent future violations?**  Yes  No

**If yes, describe**: [DESCRIBE ACTIONS]

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| **ADDITIONAL INFORMATION** |

**Is there any other information that should be provided?**  Yes  No

**If yes, describe**: [DESCRIBE ADDITIONAL INFORMATION]

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| **OFFICE USE ONLY** |

**Report received by**: [FULL NAME]

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) **Date**: [DATE]

**Follow-up action taken**: [FOLLOW-UP ACTION TAKEN]