HIPAA INCIDENT REPORT FORM

Date of Report: _____

CONTACT PERSON

Full Name: _____ **Title/Role**: _____

Signature: _____ **Date**: _____

INCIDENT DETAILS

Date of Incident: _____ **Time**: _____ ☐ AM ☐ PM

Actual Date of Incident (if known): _____

How was the incident discovered?

Type of Information Disclosed: ☐ SSN ☐ DOB ☐ Address ☐ Medical Information
☐ Other: _____

Describe the Incident:

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

VIOLATOR INFORMATION

Violator Name (if known): _____

Title/Role (if applicable): _____

Was the violation intentional? ☐ Yes ☐ No **Number of Prior Violations**: _____

CONTAINMENT

Were any containment measures made? ☐ Yes ☐ No

If yes, describe:

IMPACTED SERVICES

Were any services permanently impacted? ☐ Yes ☐ No

If yes, describe:

ADDITIONAL INFORMATION

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

If yes, describe:

OFFICE USE ONLY

Report received by: _____

Signature: _____ **Date**: _____

Follow-up action taken: