U.S. Department of Health & Human Services

Improving the health, safety, and well-being of America

Health Information Privacy

Form Approved OMB No. 0990-0346

Notice to the Secretary of HHS of Breach of Unsecured Protected Health Information

Breach Affecting:

- ○ 500 or More Individuals
- ○ Less Than 500 Individuals
- ○ Initial Breach Report
- ○ Addendum to Previous Report

Section 1 - Covered Entity

Name of Covered Entity:

Address: **State:** **Zip Code:**

Contact Name:

Contact Phone: XXX-XXX-XXXX **Contact E-mail:**

Type of Covered Entity:

Section 2 –Business Associate. Complete this section if breach occurred at or by a Business Associate.

Name of Business Associate:

Address: **State:** **Zip Code:**

Business Associate Contact Name:

Business Associate Contact Phone: XXX-XXX-XXXX **Business Associate Contact E-mail:**

Section 3 –Breach

Date(s) of Breach: MM/DD/YYYY **Date(s) of Discovery:** MM/DD/YYYY

Approximate Number of Individuals Affected by the Breach: 0

Type of Breach: Please select the type of breach. If selecting the "Other" category, please describe the type of breach in more detail in the Description section below.

- Theft
- Loss
- Improper Disposal
- Unauthorized Access
- Hacking/IT Incident

("Press Ctrl for Multiple Selections")

Location of Breached Information: Please select the location of the information at the time of the breach. If selecting the "Other" category, please describe the location of the information in more detail in the Description section below.

- Laptop
- Desktop Computer
- Network Server
- E-mail
- Other Portable Electronic Device

("Press Ctrl for Multiple Selections")

Type of Protected Health Information Involved in the Breach: Please select the type of protected health information involved in the breach. If selecting an "Other" category, please describe the information in detail in the Description section below.

U.S. Department of Health & Human Services

Improving the health, safety, and well-being of America

Health Information Privacy

Demographic Information
Financial Information
Clinical Information
Other

("Press Ctrl for Multiple Selections")

Brief Description of the Breach: Please include the location of the breach, a description of how the breach occurred, and any additional information regarding the type of breach, type of media, and type of protected health information involved in the breach.

Safeguards in Place Prior to Breach: Please indicate what protective measures were in place prior to the breach.

Firewalls
Packet Filtering (router-based)
Secure Brower Sessions
Strong Authentication
Encrypted Wireless

("Press Ctrl for Multiple Selections")

Section 4 – Notice of Breach and Actions Taken

Date(s) Individual Notice Provided: MM/DD/YYYY

Was Substitute Notice Required? Yes No

Was Media Notice Required? Yes No

Actions Taken in Response to Breach: Please select the actions taken to respond to the breach. If selecting the "Other" category, please describe the actions taken in the section below.

Security and/or Privacy Safeguards
Mitigation
Sanctions
Policies and Procedures
Other

("Press Ctrl for Multiple Selections")

Describe Other Actions Taken: Please describe in detail any actions taken following the breach in addition to those selected above.

Section 5 – Attestation

Under the Freedom of Information Act (5 U.S.C. §552) and HHS regulations at 45 C.F.R. Part 5, OCR may be required to release information provided in your breach notification. For breaches affecting more than 500 individuals, some of the information provided on this form will be made publicly available by posting on the HHS web site pursuant to § 13402(e)(4) of the Health Information Technology for Economic and Clinical Health (HITECH) Act (Pub. L. 111-5). Additionally, OCR will use this information, pursuant to § 13402(i) of the HITECH Act, to provide an annual report to Congress regarding the number and nature of breaches that are reported each year and the actions taken to respond to such breaches. OCR will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

I attest, to the best of my knowledge, that the above information is accurate.

Name: **Date:** MM/DD/YYYY

(Typing your name represents your signature.)

U.S. Department of Health & Human Services

Improving the health, safety, and well-being of America

Health Information Privacy

Submit

Burden Statement Public reporting burden for the collection of information on this complaint form is estimated to average 15 to 30 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201.

(9/09)