University of Colorado
Denver | Anschutz Medical Campus

HIPAA Incident Notification Form

Your Name: **Date:**

Your Position/Title:

Employer/Department/Clinic/Area:

Phone Number(s): **E-Mail Address:**

Date of Incident: **Date Discovered:**

Patient/Subject Name(s):

Which Institution's PHI (Which EMR)?

☐ UCHealth EPIC ☐ Children's EPIC ☐ Other

Provide a narrative of the incident including who was involved, when, and how it happened:

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Location or description of where the incident occurred:

How many individuals were affected? *Provide an exact number if known or if the exact number is not known, provide an estimate.*

Number Affected:

Describe the action taken to investigate and/or mitigate the effects of this breach:

Provide a description of what the unintended recipient did with the information inappropriately released:

Please provide documentation to hipaa@cuanschutz.edu of the recovered information or provide a reason as to why it has not been recovered.

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Is the patient/subject(s) aware of the incident?

☐ Yes

What was the behavior/demeanor of the patient/subject(s)?

☐ Cooperative ☐ Concerned/Anxious ☐ Upset/Disturbed

☐ Other

☐ No

If the patient/subject is not yet aware, please do not inform the individual(s) at this time; decisions about informing or notifying any involved patient/subject(s) will be made in collaboration with the Privacy Office after review of the incident.

Describe any anticipated potential harm to the patient/subject(s) related to the information released (financial, emotional, or other):

What processes/safeguards will be changed and/or put in place to prevent future occurrences?

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Please provide all relevant documentation about the incident (i.e., communication to the impacted individual, confirmation that the information was returned or destroyed, the data elements that were breached, etc.) to the Privacy Office at: **hipaa@cuanschutz.edu**

PROTECTED HEALTH INFORMATION

Check all that apply:

#	YES	NO	MEDIUM USED IN BREACH & STATUS
1.	☐	☐	Electronic or Computerized Data (includes e-mails, faxes)
2.	☐	☐	Paper
3.	☐	☐	Oral
4.	☐	☐	Was the data ENCRYPTED, RETURNED, and/or DESTROYED? (or otherwise rendered unusable)

Check all that apply:

#	YES	NO	DATA ELEMENTS BREACHED
1.	☐	☐	Name of Individual[s]
2.	☐	☐	Postal Address Information
3.	☐	☐	Zip Code[s]
4.	☐	☐	Date[s] of Birth
5.	☐	☐	Telephone Number[s]
6.	☐	☐	Fax Number[s]
7.	☐	☐	E-Mail Address[es]
8.	☐	☐	Social Security Number[s]
9.	☐	☐	Medical Record Number[s]
10.	☐	☐	Health Plan Beneficiary Number[s]
11.	☐	☐	Account Number[s] (Financial, Bank, Credit Card)
12.	☐	☐	Certificate/License Number[s] (Birth, Driver's, etc.)

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Check all that apply:

#	YES	NO	DATA ELEMENTS BREACHED
13.	☐	☐	Vehicle Identifier[s] and Serial Number[s], Including License Plate Number[s]
14.	☐	☐	Device Identifier[s] and Serial Number[s] (Electronic)
15.	☐	☐	Web Universal Resource Locator[s] (URLs) (Personal Sites)
16.	☐	☐	Internet Protocol (IP) Address Number[s]
17.	☐	☐	Biometric Identifiers, Including Finger, and Voice Print[s]
18.	☐	☐	Full Face Photographic Images and Any Comparable Image[s]

Other Comments:

Please email the completed form to the CU Denver | Anschutz Medical Campus Privacy Office (hipaa@cuanschutz.edu). Please provide all relevant documentation about the incident (i.e., communication to the impacted individual, confirmation that the information was returned or destroyed, the data elements that were breached, etc.) to the Privacy Office.

Office of Regulatory Compliance

University of Colorado Denver | Anschutz Medical Campus

hipaa@cuanschutz.edu

Please Note: if this occurrence is determined to be a Reportable Breach under HIPAA by the Privacy Office, please be on notice that you will be asked to provide any known contact information for the individuals affected, including updated/correct postal addresses.