Aging and Disability Services Division

Privacy Incident Report Form for Community Providers

(Community Provider Name and Program)

(Date)

(Office Address)

(Community Provider Point of Contact Name)

(Email Address)

(Point of Contact Phone Number)

(Person Making Report First, Last Name)

(Person Reporting Phone Number)

(Email Address)

Instructions: This form is used to report alleged violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Immediately upon discovery of the incident, notify your supervisor (if applicable) and then submit the completed form.

Complaints regarding specific acts of alleged privacy violations affecting particular individuals cannot be investigated anonymously but information about the alleged victim and individual filing the report will be shared only with those directly involved.

Filing a complaint regarding alleged or suspected privacy violations with Aging and Disability Services Division (ADSD) will not result in retaliatory actions against the alleged victim or the reporter. If the alleged victim or reporter is not satisfied with the outcome of the investigation, they are entitled to file a complaint with the U.S. Department of Health and Human Services.

Incident Type

☐ Self-Reported ☐ Witness-Reported

(Date of Incident)

(*If Witness Reported: Person/Agency Office Address and Program)

Provide a detailed description of the alleged incident (or incidents) including the party or parties to whom protected health information (PHI) was erroneously disclosed; names of witnesses; what specific PHI was disclosed; circumstances resulting in the disclosure; actions taken by your staff and supervisor (if applicable).

Clear Form