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| --- |
| HIPAA/DATA INCIDENT REPORT |
| Michigan Department of Health and Human Services |
|  |
| Today’s Date | Date of Incident | Time of Incident (if applicable) | Date Incident Discovered |
|       |       |       |       |
|  |
| **Contact Information** |
| Your Name | MDHHS Division/Section |
|       |       |
| Your Phone Number | Your Email |
|       |       |
| Your Location | Your Supervisor |
|       |       |
|  |
| **Incident Information** |
| Location of Incident (if applicable) | Incident Type |
|       |  |
| If “Other” is chosen in “Incident Type,” explain below |
|       |
| In what medium was the information disclosed? |  |
|  |  |
| If Other, explain below |
|       |
| Police Report Number and Agency (if applicable) |  |
|       |
| Is your office a HIPAA-covered entity? | Was the information encrypted and password protected? |
| [ ]  Yes | [ ]  No | [ ]  Unknown | [ ]  Yes | [ ]  No | [ ]  Unknown | [ ]  Other |
| If Other, explain below |
|       |
| Item/Equipment Involved |  |
|  |  |
| If Other, explain below |
|       |
| Describe what happened |
|       |
| Did a vendor or other entity outside of MDHHS disclose the information? | If yes, is there any sort of agreement with the other entity? |
| [ ]  Yes | [ ]  No | [ ]  Unknown | [ ]  Yes | [ ]  No | [ ]  Unknown | [ ]  N/A |
| The number of people whose information was disclosed | How many people in total does your program serve? |
|       |       |
|  |
| **Nature and Extent of Information Involved** |
| Financial Information(check all that apply) | Health Information(check all that apply) | Clinical Information(check all that apply) |
| [ ]  Credit Cards | [ ]  STDs/STIs | [ ]  Treatment Plan |
| [ ]  Social Security Numbers | [ ]  Mental Health Information | [ ]  Diagnoses |
| [ ]  Account Numbers | [ ]  HIV/AIDS | [ ]  Medication |
| Describe: |       |  | [ ]  Substance Abuse | [ ]  Medical History |
| [ ]  Other: |       |  | [ ]  Other: |       |  | [ ]  Test Results |
|  |  | [ ]  Other: |       |  |
|  |  |  |  |  |
|  |
| **What Identifiers are Involved (check all that apply)** |
| [ ]  Names | [ ]  Medicaid Recipient Numbers | [ ]  Internet Protocol (IP) Address Number |
| [ ]  Addresses | [ ]  Health Plan Beneficiary Numbers | [ ]  Finger or Voice Prints |
| [ ]  Dates | [ ]  Certificate/License Numbers | [ ]  Any other Unique Number, Characteristic, or Code that may identify an individual |
| Describe:  |  |  | [ ]  Account Numbers |
| [ ]  Telephone Numbers | [ ]  Web Universal Resource Locator (URL) [ ]  Any Vehicle or Other Device Serial Numbers | [ ]  Other: |       |  |
| [ ]  Fax Numbers |  |  |
| [ ]  Social Security Numbers |  |  |  |
| [ ]  Email Addresses |  |  |
| [ ]  Medical Record Numbers  |  |  |  |  |
|  |  |  |  |
| Has the information that was used or disclosed been reviewed by the Institutional Review Board (IRB)? |
| [ ]  Yes | [ ]  No | [ ]  Unknown | [ ]  N/A |
| What security policies/procedures are involved? |  |
|       |
| Were those policies/procedures followed? |
| [ ]  Yes | [ ]  No | [ ]  N/A |
| Have you attempted to retrieve the information? [ ]  No [ ]  Yes – If Yes, explain. |
|       |
| Additional comments |
|       |
|  |  |  |  |
|  | **Save document and email to:****MDHHSPrivacySecurity@michigan.gov** |  |  |