LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
HIPAA PRIVACY INCIDENT/BREACH REPORTING FORM

Disclaimer:

The information provided in this form is intended to report potential privacy incidents or breaches. The report includes important information that shall be used solely for the purpose of reporting the possible violations of clients rights to privacy and protected health information.

The purpose of this form is to ensure that incidents are properly documented, investigated and addressed according to applicable federal and state privacy laws and Department of Mental Health (DMH) privacy policies and procedures. Please be assured that all information provided in this report will be treated with the highest level of confidentiality and only shared with authorized personnel involved in the investigation and resolution of the reported incident. By submitting this form, you acknowledge that you have read the aforementioned disclaimer and understand that you may be contacted for additional information as needed.

Date of Report: ________________, 20___

1. PERSON FILING THIS REPORT

Full Name: ________________________________Title: ________________

Phone: (____) _____-_________E-Mail: ________________________________

2. THE INCIDENT

Date of incident: ________________, 20____Time: ____:_____☐ AM ☐ PM

Describe the device(s) affected: ____

Name of staff allegedly responsible or involved in the incident. ___________________

Has staff completed the HIPAA Privacy/Security trainings? ☐ Yes ☐ No

Describe the incident (in full). Include location, date, time and name/email of staff involved:

3. PERSONAL HEALTH INFORMATION (PHI)

Was there client protected health information compromised by the incident? ☐ Yes ☐ No

If yes, how many clients impacted? _____

If available, please attach a list of the clients' names and addresses.

Type of protected information used/disclosed without authorization. (Check all that apply)

☐ Name

☐ Address

☐ Date of Birth

☐ Medical record number

☐ Social Security Number

☐ Diagnosis/Condition

☐ Medication

☐ Other ____________________

4. CONTAINMENT

What mitigation steps have been taken (staff counseling, deleted e-mails, etc.)?

5. IMPACTED SERVICES

Has the incident resulted in an interruption of client services? ☐ Yes ☐ No

If yes, please describe:

6. OTHER

Is there any other information you would like to include? ☐ Yes ☐ No

If yes, describe:

7. PERSON FILING REPORT

Signature: ____________________________ Date: ________________________

Print Name: ___________________________