Department of Transformation and Shared Services
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Health Insurance Portability and Accounting Act [HIPAA] Disclosure Reporting Form

Name of Benefit Coordinator/Agency/School District:

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Date of data breach: _______________

Date reported to privacy office: _______________

Reporting person & office: ____

Member's whose PHI was disclosed:

Name: ___________________________________ DOB: _______________

SSN: _______________ ID #: _______________

Incident description:

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Protected Health Information Disclosed:

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Was the PHI destroyed or Returned? _______________

Name and Address of person who received PHI:

Name: ________________________ Address: ____

Corrective Action Plan: (Please explain action taken to correct the situation and to prevent from future occurrence.)

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Note: Please attach copies of all information/documents disclosed

For EBD Use Only:

Date member notified: _______________ Date HHS notified: _______________

Provide copy of member notification