Department of Transformation and Shared Services

AR BENEFITS

Toll Free: (877) 815-1017 Fax: (501) 682-2366 www.transform.ar.gov/empolyee-benefits/

Health Insurance Portability and Accounting Act [HIPAA] Disclosure Reporting Form

Name of Benefit Coordinator/Agency/School District:

_____

Date of data breach: _____ Date reported to privacy office: _____

Reporting person & office: _____

Member's whose PHI was disclosed:

Name: _____ DOB: _____

SSN: _____ ID #: _____

Incident description:

_____

_____

_____

_____

Protected Health Information Disclosed:

_____

_____

_____

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):

_____

_____

_____

Note: Please attach copies of all information/documents disclosed

For EBD Use Only:

Date member notified: _____ Date HHS notified: _____

Provide copy of member notification