

## PRIVACY INCIDENT REPORT      Protected Health Information

Report Date:		Incident Date / Time:		Incident Location:	
Name and Address of Patient whose PHI is involved (If more than one, list on back of this form, or provide list)					
Nature of Incident:					
Harm or Negative Outcome				Is the patient aware of the incident?	
				YES      NO	
Persons Involved in this Incident					
Name		Title/Position		Can be reached at:	
How was this person involved?					
Name		Title/Position		Can be reached at:	
How was this person involved?					
Name		Title/Position		Can be reached at:	
How was this person involved?					
Health Information Involved:		Describe the Health Information involved in as much detail as possible: (Check all that apply)			
<input type="checkbox"/> Electronic Records <input type="checkbox"/> Paper Records <input type="checkbox"/> Other		<input type="checkbox"/> Patient Name <input type="checkbox"/> Patient Address <input type="checkbox"/> Medical Record # <input type="checkbox"/> Diagnosis <input type="checkbox"/> Social Security # <input type="checkbox"/> Financial Information Other Information – Please Describe:			
Who was Notified of this Incident? (Names and Titles)					
Immediate Remedial Actions / Interventions, if any:					

Report Completed By (please print): \_\_\_\_\_

Title: \_\_\_\_\_ College / Dept / Clinic / Area: \_\_\_\_\_

I can be contacted at: \_\_\_\_\_ or \_\_\_\_\_

Signature: \_\_\_\_\_