# **U.S. Department of Health & Human Services**

Improving the health, safety, and well-being of America

## **Health Information Privacy**

Form Approved OMB No. 0990-0346

Breach Affecting:	Report Ty	De:	
500 or More Individuals	ී Initial Bi	○ Initial Breach Report  ○ Addendum to Previous Report	
Cless Than 500 Individuals	○ Addendu		
Section 1 - Covered Entity			
Name of Covered Entity:			
Address:	City:	State: Zip Code:	
Contact Name:			
Contact Phone: XXX-XXX-XXXX	Contact E-mail:		
Type of Covered Entity:	<u>\_</u>		
Section 2 -Business Associate	Complete this section if hree	ich occurred at or by a Business Associate.	
Name of Business Associate:		······································	
Address:	City:	State: v Zip Code:	
		State	
Business Associate Contact Name:		· · · · · · · · · · · · · · · · · · ·	
		ss Associate Contact E-mail:	
Business Associate Contact Name:			
Business Associate Contact Name:  Business Associate Contact Phone: >		ss Associate Contact E-mail:	
Business Associate Contact Name:  Business Associate Contact Phone: >  Section 3 -Breach	Date(s) of Discovery:	ss Associate Contact E-mail:	
Business Associate Contact Name:  Business Associate Contact Phone: >  Section 3 -Breach  Date(s) of Breach: MM/DD/YYYY  Approximate Number of Individuals	Date(s) of Discovery:  Affected by the Breach: 0	ss Associate Contact E-mail:	
Business Associate Contact Name:  Business Associate Contact Phone: >  Section 3 -Breach  Date(s) of Breach: MM/DD/YYYY  Approximate Number of Individuals	Date(s) of Discovery:  Affected by the Breach: 0 of breach. If type breach is "	MM/DD/YYYY  Other", please describe the type of breach in field below.	
Business Associate Contact Name:  Business Associate Contact Phone: >  Section 3 -Breach  Date(s) of Breach: MM/DD/YYYY  Approximate Number of Individuals  Type of Breach: Please select the type	Date(s) of Discovery:  Affected by the Breach: 0 of breach. If type breach is "	MM/DD/YYYY  Other", please describe the type of breach in field below.	

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**Brief Description of the Breach:** Please include the location of the breach, a description of how the breach occurred, and any additional information regarding the type of breach, type of media, and type of protected health information involved in the breach.

Safeguards in Place Prior to Breach: Please indicate what protective measures were in place prior to the breach.
Firewalls ^
Packet Filtering (router-based)
Secure Brower Sessions
Strong Authentication
Encrypted Wireless
Physical (3年時被Multiple Selections")
Logical Access Control
Anti-Virus Software
Intrusion Detection
Section 4 – Notice of Breach and Actions Taken
Date(s) Individual Notice Provided: MM/DD/YYYY
Was Substitute Notice Required? OYes No
Was Media Notice Required? OYes ONO
Actions Taken in Response to Breach: Please select the actions taken to respond to the breach. If selecting the "Other" category, please
Actions Taken in Response to Breaking below
describe the actions taken in the section below.
Security and/or Privacy Safeguards
Mitigation
Sanctions
Policies and Procedures
Other
("Press Ctrl for Multiple Selections")
Describe Other Actions Taken: Please describe in detail any actions taken following the breach in addition to those selected above.
Describe Other Actions Taken: Please describe in detail any decions taken following the oreact in detailed to

#### Section 5 - Attestation

Under the Freedom of Information Act (5 U.S.C. §552) and HHS regulations at 45 C.F.R. Part 5, OCR may be required to release information provided in your breach notification. For breaches affecting more than 500 individuals, some of the Information provided on this form will be made publicly available by posting on the HHS web site pursuant to § 13402(e)(4) of the Health Information Technology for Economic and Clinical Health (HITECH) Act (Pub. L. 111-5). Additionally, OCR will use this information, pursuant to § 13402(i) of the HITECH Act, to provide an annual report to Congress regarding the number and nature of breaches that are reported each year and the actions taken to respond to such breaches. OCR will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

I attest, to the best of my knowledge, that the above information is accurate.

Name: Da	ite: MM/DD/YYYY
(Typing your name represents your signat	ure.)
Submit	

Burden Statement Public reporting burden for the collection of information on this complaint form is estimated to average 15 to 30 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201.

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