Agency for Health Care Administration
Health Plan Privacy Incidents/Breaches Reporting Form

Instructions: Fill out form as completely as possible for initial report; submit any necessary addenda upon further investigation. Transmit via secure email to AHCA Contract Manager. Treat this form as **confidential**. Add attachments with additional information as needed.

Health plan name: _____

Plan type: **--Select--** Three character plan identifier: **--Select--**

Health plan HIPAA compliance contact: _____

Phone number: _____ *extension:* _____

Email Address: _____

Is this the initial reporting of an incident or an addendum to previous report? **--Select--**

If addendum, give case or reference number: _____

Disclosure incident committed by: **--Select--**

Actual occurrence date(s) of disclosure(s): _____

Date first known to health plan (discovery date): _____

Date health plan informed AHCA Contract Manager: _____

Incident type:

- **--Select all that apply using CTRL--**
- **Hacking/IT incident**
- **Improper disposal**
- **Loss**
- **Misaddressed/misdelivered mail**
- **Misdirected FAX**
- **Missent email**
- **Theft**

If Other:

Incident location:

- **--Select all that apply using CTRL--**
- **Desktop computer**
- **Electronic medical record**
- **Email**
- **FAX machine**
- **Laptop computer**
- **Mail service**
- **Network server**
- **Other portable electronic device**
- **Paper/films**
- **Other**

If Other:

Number of members affected: _____ or ☐ To be determined

Information disclosed:

--Select all that apply using CTRL--
Diagnosis/Conditions
Lab results
Medications
Other treatment information
Address/ZIP
Date of birth
Drivers license
Medicaid ID #

Format of information disclosed:

--Select--

Description of incident/how incident occurred:

Is disclosure assessed as a breach by health plan? --Select--

If breach determined, were affected individual(s) notified? --Select--

If Yes, date of individual(s) notification: _____

Method of notification: --Select--

If breach determined, was HHS/OCR notified? --Select--

If Yes, date of HHS/OCR notification: _____

If more than 500 affected individuals, was the media notified? --Select--

If Yes, date of media notification: _____

Case number (if any) assigned to incident by health plan: _____

If incident was caused by a *health plan employee*:

- **Send a copy of any breach risk assessment completed per 45 CFR 164.402(2).**
- **If also assessed as a breach, answer the following questions.**

Safeguards in place prior to breach occurrence:

--Select all that apply using CTRL--
Privacy rule safeguards (training, policies and procedures, etc.)
Security rule administrative safeguards (risk analysis, risk management, etc.)
Security rule physical safeguards (facility access controls, workstation security, etc.)
Security rule technical safeguards (access controls, transmission security, etc.)
None

Actions taken in response to breach:

--Select all that apply using CTRL--
Adopted encryption technologies
Changed password/strengthened password requirements
Created a new/updated Security Rule Risk Management Plan
Implemented new technical safeguards
Implemented periodic technical and nontechnical evaluations
Improved physical security
Performed a new/updated Security Rule Risk Analysis
Provided individuals with free credit monitoring
Revised policies and procedures
Sanctioned workforce members involved (including termination)
Took steps to mitigate harm
Trained or retrained workforce members
Other

If Other: