Davis Wright Tremaine LLP

TEMPLATE FOR

NOTIFICATION OF BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

TO THE SECRETARY OF HEALTH AND HUMAN SERVICES (HHS)

HEALTH INFORMATION PRIVACY

This is a template developed from information and guidance on the HHS Office for Civil Rights website for notification to the Secretary of HHS of a breach of unsecured protected health information. It is designed to provide assistance to covered entities and business associates providing breach notifications through the OCR website. This template is neither legal advice nor an official version of what is required to be submitted. An attorney should be contacted for specific questions about the template. This template is as of February 23, 2021, and Davis Wright Tremaine undertakes no obligations to update it as the HHS website may change from time to time.

FOR MORE INFORMATION:

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BREACH PORTAL REQUIRED INFORMATION
All information with an asterisk is required.

GENERAL Information Screen: Please supply the required general information for the breach.

*Report Type: What type of breach report are you filing? ☐ Initial Breach Report ☐ Addendum to Previous Report

If Addendum to Previous Report is selected:

*Do you have a valid breach tracking number? A breach tracking number would have been provided by OCR after January 1st, 2015. If you do not have a number please select 'No'. ☐ Yes ☐ No

Breach Tracking Number: Please **supply** your breach tracking number. [ ]

CONTACT Information Screen: Please supply the required contact information for the breach.

☐ Are you a Covered Entity who experienced a breach, and are filing on behalf of your organization?
☐ Are you a Business Associate who experienced a breach, and are filing on behalf of a Covered Entity?
☐ Are you a Covered Entity filing because your Business Associate experienced a breach?

If *"Are you a Covered Entity who experienced a breach, and are filing on behalf of your organization"* **was selected:**

Covered Entity: Please provide the following information.

*Name of Covered Entity (Name of Entity only (not of its representative), no abbreviations, no acronyms): [ ]

*Type of Covered Entity:
☐ Health Plan
☐ Healthcare Clearing House
☐ Healthcare Provider

Street Address Line 1: [ ]

Street Address Line 2: [ ]

*City: [ ]

*State: [ ]

*ZIP:

Covered Entity Point of Contact Information:

*First Name: *Last Name:

*Email:

*Phone Number: (Include area code):	**Phone Number**	**Usage**	Add additional phone
		☐ Home/Cell ☐ Work	

If *"Are you a Business Associate who experienced a breach, and are filing on behalf of a Covered Entity"* **was selected:**

Business Associate: Completion of this section is required if the breach occurred at or by a Business Associate or if you are filing on behalf of a Covered Entity.

*Name of Business Associate:

*Street Address Line 1:

Street Address Line 2:

*City

*State (Choose state)

*Zip

Business Associate Point of Contact Information:

*First Name: *Last Name:

*Email:

*Phone Number: (Include area code):	**Phone Number**	**Usage**	Add additional phone
		☐ Home/Cell ☐ Work	

Enter the contact information for all Covered Entities on whose behalf you are filing.

Covered Entity 1

*Name of Covered Entity (not of its representatives, no abbreviations, no acronyms):	
*Street Address Line 1:	
Street Address Line 2:	
*City	
*State (Choose state)	
*Zip	

Point of Contact Information

*First Name:		*Last Name:	
*Email:			

*Phone Number: (Include area code):	**Phone Number**	**Usage**	Add additional phone
		☐ Home/Cell ☐ Work	

*Type of Covered Entity:
- ☐ Health Plan
- ☐ Healthcare Clearing House
- ☐ Healthcare Provider

If you *"Are a Covered Entity filing because your Business Associate experienced a breach"* **was selected:**

Covered Entity: Please provide the following information.

*Name of Covered Entity (Name of Entity only (not of its representative), no abbreviations, no acronyms):	

*Type of Covered Entity:
- ☐ Health Plan
- ☐ Healthcare Clearing House

☐ Healthcare Provider

*Street Address Line 1:	
Street Address Line 2:	
*City:	
*State:	
*ZIP:	

Covered Entity Point of Contact Information

*First Name:		*Last Name:	
*Email:			

*Phone Number: (Include area code):

Phone Number	Usage	Add additional phone
	☐ Home/Cell ☐ Work	

Business Associate: Completion of this section is required if the breach occurred at or by a Business Associate

*Name of Business Associate (Name of Business Associate only, no abbreviations, no acronyms):	
*Street Address Line 1:	
Street Address Line 2:	
*City	
*State (Choose state)	
*Zip	

Business Associate Point of Contact Information

*First Name:		*Last Name:	

*Email:

*Phone Number: (Include area code):

Phone Number	Usage	Add additional phone
	☐ Home/Cell ☐ Work	

BREACH Information Screen

*Breach affecting: How many individuals are affected by the breach? ☐ 500 or More Individuals ☐ Fewer Than 500 Individuals

Breach Dates: Please provide the start and end date (if applicable) for the dates the breach was discovered.

*Breach Start Date:

*Breach End Date:

Discovery Dates: Please provide the start and end date (if applicable) for the dates the breach was discovered.

*Discovery Start Date:

*Discovery End Date:

*Approximate Number of Individuals Affected by the Breach:

*Type of Breach:
- ☐ Hacking
- ☐ Work
- ☐ Improper Disposal Help
- ☐ Loss Help
- ☐ Theft Help
- ☐ Unauthorized Access/Disclosure Help

*Location of Breach:
- ☐ Desktop Computer
- ☐ Electronic Medical Record
- ☐ Email
- ☐ Laptop
- ☐ Network Server
- ☐ Other Portable Electronic Device

	☐ Paper/Films ☐ Other
*Type of Protected Health Information Involved in Breach:	☐ **Clinical** ☐ Diagnosis/Conditions ☐ Lab Results ☐ Medications ☐ Other Treatment Information ☐ **Demographic** ☐ Address/ZIP ☐ Date of Birth ☐ Driver's License ☐ Name ☐ SSN ☐ Other Identifier ☐ **Financial** ☐ Claims Information ☐ Credit Card/Bank Acct # ☐ Other Financial Information
	☐ **Type of Protected Health Information involved in Breach (Other):** [4,000 characters limit]
Brief Description of the Breach: [4,000 characters limit]	
*Safeguards in Place Prior to Breach:	☐ None ☐ 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.)

NOTICE OF BREACH AND ACTIONS TAKEN Information Screen

*Individual Notice Provided Start Date: [ ]

Individual Notice Provided Projected/ Expected End Date: [ ]

Was Substitute Notice Required?

☐ Yes

☐ Fewer than 10 ☐ 10 or more

☐ No

Was Media Notice Required?

☐ Yes

☐ Select State(s) and/or Territories in which media notice was provided

-- Choose State - District of Colombia

☐ No

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*Actions Taken in Response to Breach:

☐ 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 business associate with additional training on HIPAA requirements
☐ Provided individuals with free credit monitoring
☐ Revised business associate contracts
☐ Revised policies and procedures
☐ Sanctioned workforce members involved (including termination)
☐ Took steps to mitigate harm
☐ Trained or retrained workforce members
☐ Other

*Describe Other Actions Taken: [4,000 characters limit]	

ATTESTATION Information Screen

Please complete the Attestation form.

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**	**Date**