



Privacy and Security Incident Reporting Form

Reporting Party: _____ Date: _____

Detailed Description of Privacy Incident:

[Large empty box for detailed description of privacy incident]

Clinic/Program Involved:

- DBH: Program
- Contractor Agency

Date Discovered: _____ # of Clients Affected: _____

Date Occurred: _____ # of Minors: _____

Date Reported: _____ [DBH Only] Client ID#: _____

myAvater [Misfiling Only] Correct Client ID # _____ Incorrect Client ID# _____

myAvater [Misfiling Only] Correct Client ID # _____ Incorrect Client ID# _____

Was **Mental Health** PHI Involved? Yes (WIC 5328/HIPAA regs applicable) No

Was **SUD** PHI Involved? Yes (42 CFR Part 2 regs applicable) No

***Note:** Protections under 42 CFR Part 2 apply only when a client's SUD PHI originates from a federally assisted Part 2 program. If it does not, the information is not protected under Part 2.*

Was the PHI or PII in question acquired or used in the administration of the **Medi-Cal** program? Yes (Medi-Cal Data Privacy and Security Agreement with DBH/DHCS Applies) No

Responsible Party who caused incident (Name, title, email address, and telephone number and job duties):

[Empty box for responsible party information]

Which of the **18 HIPAA identifiers** of PHI were potentially compromised (select all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Client Name | <input type="checkbox"/> Social Security Numbers | <input type="checkbox"/> Device attributes or serial numbers |
| <input type="checkbox"/> Street address, city, county, or zip code | <input type="checkbox"/> Medical record numbers (Avatar/Simon, etc...) | <input type="checkbox"/> Digital identifiers, such as website URLs |
| <input type="checkbox"/> DOB <input type="checkbox"/> Date of Admission | <input type="checkbox"/> Health insurance beneficiary numbers | <input type="checkbox"/> Biometric elements, including finger, retinal, and voiceprints |
| <input type="checkbox"/> DOD <input type="checkbox"/> Date of Discharge | | |
| <input type="checkbox"/> Other Date: _____ | | |
| <input type="checkbox"/> Telephone numbers | <input type="checkbox"/> Account Numbers | <input type="checkbox"/> IP Addresses |
| <input type="checkbox"/> Fax Numbers | <input type="checkbox"/> Certificate/License Numbers | <input type="checkbox"/> Full face photographic images |
| <input type="checkbox"/> Email Addresses | <input type="checkbox"/> Vehicle Identifiers | <input type="checkbox"/> Other identifying numbers or codes |



Privacy and Security Incident Reporting Form

Mitigation Efforts	Information is: <input type="checkbox"/> Electronic <input type="checkbox"/> Hard Copy <input type="checkbox"/> Verbal
	<input type="checkbox"/> Written attestation was secured (please provide)
	<input type="checkbox"/> PHI was secured, recovered, deleted from both email inbox and deleted items folder (if ePHI).
	Were any other agencies notified?
	Was a police report filed (include #)?
	←Enter on the left: What mitigating efforts were taken thus far? Describe what action was taken to ensure the incident was immediately addressed and further threats of PHI/PII exposure was mitigated.
	For additional reporting and privacy incident guidance, see the Privacy Incident Policy (COM0944) .
Administrative & Personnel Information	Direct supervisor's name, title, and credential(s) for the party that caused the incident:
	Supervisor was notified on (MM/DD/20XX):
	Has this party been involved in a potential privacy incident before? (Is this incident their second, third, fourth, etc.?) If yes, was it for the same type of incident (if known)?
	Date of last HIPAA annual training for party that caused the Incident (supervisor to provide - MM/DD/20XX):
	Deputy Director over program:
	Send all PHI in this form, copies of emails, forms, etc. that were compromised <u>encrypted</u>.
SUBMIT THIS FORM TO: DBH-PrivacyIncidents@dbh.sbcounty.gov	