

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 15, 2024, and Davis Wright Tremain undertakes no obligations to update it as the HHS website may change from time to time.

**FOR MORE  
INFORMATION:**

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## 1. BREACH NOTIFICATION TEMPLATE

### Notice to Secretary of Health and Human Services Breach of Unsecured Protected Health Information (As of 2/15/24)

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

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

\* Breach Tracking Number: Please supply your breach tracking number

\* Please select one of the following:

- Are you a Covered Entity filing on behalf of your organization?
- Are you a Business Associate filing on behalf of a Covered Entity?
- Are you a Covered Entity filing on behalf of a Business Associate?

**DWT Note:** *Depending on the box checked, the following windows may appear*

**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, or 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

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**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.

\* Name of Business Associate:   
(No abbreviations, no acronyms):

\* Street Address Line 1:

Street Address Line 2:

\* City:

\* State:

\* ZIP:

**Business Associate Point of Contact Information**

\* First Name:  \* Last Name:

\* Email:

\* Phone Number:  (Include area code):

Phone Number	Usage	Add additional phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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**Covered Entity 1**

[Add](#) | [Remove](#)

\* Name of Covered Entity:  
**(No abbreviations, no acronyms):**

\* Street Address Line 1:

Street Address Line 2:

\* City:

\* State:

\* ZIP:

**Point of Contact Information**

\* First Name:  \* Last Name:

\* Email:

	Phone Number	Usage	Edit	Add additional phone
* Phone Number: (Include area code):	<input type="text"/>	<input type="text"/>	<a href="#">Remove</a>	<input type="text"/>

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\* Type of Covered Entity (Health Plan, Healthcare Clearing House, or Healthcare Provider)

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**If "Are you 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, or Healthcare Provider)

\* Street Address Line 1:

Street Address Line 2:

\* City:

\* State:

\* ZIP:

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**Covered Entity Point of Contact Information**

\* First Name:  \* Last Name:

\* Email:

\* Phone

Number:  
(Include  
area code):

Phone Number
<input type="text"/>

Usage
<input type="text"/>

Add additional phone

<input type="text"/>
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**Business Associate:** Completion of this section is required if the breach occurred at or by a Business Associate.

\* Name of Business Associate:   
**(No abbreviations, no acronyms):**

\* Street Address Line 1:

Street Address Line 2:

\* City:

\* State:

\* ZIP:

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**Breach:** Please supply the required information for the breach.

- \* 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 occurred in.

\* 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:

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\* Type of Breach:

- Hacking/IT Incident
  - Improper Disposal
  - Loss
  - Theft
  - Unauthorized Access/Disclosure
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\* 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):**

\* Brief Description of the Breach:

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\* 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: Please supply the required information about notices and actions.

\* Individual Notice Provided Start Date:  Individual Notice Provided Projected/Expected End Date:

Was Substitute Notice Required?  Yes  No  
 Fewer than 10  10 or more  
 Yes  No

Was Media Notice Required? (If yes, select State(s) and/or Territories in which media notice was provided)

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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:

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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:

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Summary: Please review the information on this page for accuracy. When finished, please select the "Submit This Breach Notification" button at the bottom to submit the breach notification.

If you have any additional information to add to your breach notification, you may call 1-800-368-1019. Please reference the number given by OCR when submitting your breach report.