PURDUE UNIVERSITY
RECORD OF INADVERTENT DISCLOSURE OF
PROTECTED HEALTH INFORMATION

The following information should be entered by the person who inadvertently disclosed, or if unknown, the person who discovered the inadvertent disclosure. Both pages should be provided to the Office of Legal Counsel after completion.

Covered Component **Date(s) of Inadvertent Disclosure**

Person(s) or entity whose information was disclosed:

Name:

ID# or Date of Birth (if needed for filing):

Address (if known):

Phone (if known):

Person(s) or entity who received the information:

Name:

Address (if known):

Phone (if known):

Name:

Address (if known):

Phone (if known):

The following information was accessed or disclosed (include detail: name, address, PUID, etc.):

This page to be included in the medical record, if covered component is a covered healthcare provider, or should be maintained by the Office of Legal Counsel in a file of inadvertent disclosures.

THIS PAGE FOR INTERNAL USE ONLY *(Not to be filed with patient medical record)*

The following information should be entered by the person who inadvertently disclosed, or if unknown, the person who discovered the inadvertent disclosure or disclosed in violation of the minimum necessary. *Please include a copy of the information disclosed, if reasonable.*

Covered Component **Date(s) of Inadvertent Disclosure**

Date Disclosure Discovered: _____

Person(s) or entity whose information was disclosed:

Name:

ID# or Date of Birth (if needed for filing):

Person who inadvertently disclosed protected health information:

Name: Title:

Phone:

How was the information inadvertently accessed or disclosed?

After the disclosure was discovered, how was the disclosure mitigated?

Confidentiality Agreement obtained? Date Requested: _____

Date Received: _____

Paper or electronic PHI in custody of the recipient:

Date Requested to be Returned or Destroyed: _____

Date Returned by Recipient: _____ Date Destroyed: _____

Destruction Certificate obtained? Date Requested: _____

Date Received: _____

Other mitigation and how was the information destroyed, if applicable:

Risk Assessment Data

Please indicate which identifiers were involved in the use or disclosure that relate to the individual or of relatives, employers, or household members of the individual:

Identifier	Individual	Relative	Employer	Household Member
Names	☐	☐	☐	☐
Street address, city, county, precinct, zip code	☐	☐	☐	☐
Dates directly related to an individual, including birth date, admission/discharge date, date of death	☐	☐	☐	☐
Telephone numbers	☐	☐	☐	☐
Fax numbers	☐	☐	☐	☐

Identifier	Individual	Relative	Employer	Household Member
Electronic mail addresses	☐	☐	☐	☐
Social security numbers	☐	☐	☐	☐
Medical record numbers	☐	☐	☐	☐
Health plan beneficiary numbers	☐	☐	☐	☐
Account numbers	☐	☐	☐	☐
Certificate / license numbers	☐	☐	☐	☐
Vehicle identifiers and serial numbers, including license plate numbers	☐	☐	☐	☐
Device identifiers and serial numbers	☐	☐	☐	☐
Web Universal Resource Locators (URLs)	☐	☐	☐	☐
Internet Protocol (IP) address numbers	☐	☐	☐	☐
Biometric identifiers, including finger and voice prints	☐	☐	☐	☐
Full face photographic images and any comparable images	☐	☐	☐	☐
Any other unique identifying number, characteristic, or code (e.g. PUID)	☐	☐	☐	☐

Categories of Information Disclosed:

Clinical
- ☐ Diagnosis / Conditions
- ☐ Lab Results
- ☐ Medications
- ☐ Other Treatment Information (list below)

Demographic
- ☐ Address / ZIP
- ☐ Date of Birth
- ☐ Driver's License
- ☐ Name
- ☐ SSN

Financial
- ☐ Claims Information
- ☐ Credit Card / Bank Acct #
- ☐ Other Financial Information

Other
Please list below:

Is the recipient of the information covered by HIPAA (if you are not sure, ask the recipient)? ☐ YES ☐ NO

Name of person filling out this form: _____

Signature: _____ **Date:** _____

Phone: _____

The following should be entered by the HIPAA Liaison:

How did HIPAA Liaison follow up to prevent this incident from recurring?

_____

_____

_____

_____

_____

Signature of area HIPAA Liaison: _____ **Date:** _____

HIPAA Liaison: After investigation, send entire form copy to:
The Office of Legal Counsel, 610 Purdue Mall, West Lafayette, IN 47907

Providers: File page 1 in medical record; file all pages in HIPAA Liaison file.

Non-Providers: File all pages in HIPAA Liaison file.