HIPAA Violation Form

Send Notification to: compliance@firstcare.com

All known or suspected disclosures must be documented and emailed to the Corporate Compliance Department immediately or no less than 24 hours from discovery. Complete this form electronically and send all associated documentation that was inadvertently shared, as well as, the corrected documentation. Please contact the Corporate Compliance Department with any questions at 1(866) 399-8161.

DO NOT USE ABBREVIATIONS AND SPELL OUT ALL ACRONYMS.

Individual Completing the Form			
Full Name:		**Title & Department:**	
Individual Who Disclosed PHI			
Full Name:		**Title & Department:**	
Violation Information			
Date Incident Occurred:		**Date Incident was Discovered:**	
Type of Violation:	☐ Suspected unauthorized disclosure of PHI ☐ Suspected improper disposal of PHI ☐ Suspected unauthorized access of PHI ☐ Alleged forwarding of unsecured PHI		
Individuals Affected by Disclosure			
Number Impacted: *(How many individuals were impacted by this disclosure)*			
Provide the following Information for those Affected by the Disclosure: *(Complete Attachment 1 to report more than 3 members)*			

Full Name of 1st Member:	**Member ID:**	**Medicaid/CHIP Coverage:**
		☐ Yes ☐ No *(If yes, provide information below)*

Address:		**Age:**		**Telephone Number:**	

Full Name of 2nd Member:	**Member ID:**	**Medicaid/CHIP Coverage:**
		☐ Yes ☐ No *(If yes, provide information below))*

Address:		**Age:**		**Telephone Number:**	

Full Name of 3rd Member:	**Member ID:**	**Medicaid/CHIP Coverage:**
		☐ Yes ☐ No *(If yes, provide information below)*

Address:		**Age:**		**Telephone Number:**	

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Recipient Information		
Was PHI Shared with Anyone who Should Not have seen the Information:	☐ Yes *(If yes, provide the unintended recipient(s) below)* ☐ No:	
Unintended Recipient Name:		**Recipient was:** ☐ Provider ☐ Member ☐ Vendor ☐ Other (Explain):
Unintended Recipient Name:		**Recipient was:** ☐ Provider ☐ Member ☐ Vendor ☐ Other (Explain):
Unintended Recipient Name:		**Recipient was:** ☐ Provider ☐ Member ☐ Vendor ☐ Other (Explain):

Description of Disclosure	
List all Known and/or Suspected Types of PHI Included in the Disclosure: *(Name, Address, Date of Birth, Social Security Number, Member ID, Discharge Date, Telephone Number, etc.)*	
What Type of Disclosure was It: *(Explanation of Benefits, Prior Authorization, Identification Card, etc.)*	
In what Form of Communication was the Disclosure Released: *(Fax, Email, Mail, Verbally, etc.)*	
Briefly Explain what Happened and Include How You were Made Aware:	

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Corrective Actions Immediately Taken	
Briefly Describe the Corrective Action(s) Taken: *(The Corporate Compliance Department may Request a Detailed Corrective Action Plan (CAP) upon Submission of this Form)*	
Attestation	
By signing below, I attest to the best of my knowledge that the above information is true and correct.	
Type Full Name:	
Date: *(mm/dd/yyyy)*	