42 CFR Part 2 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 Part 2 Record breach tracking number? If you do not have a number, please select 'No'.

- Yes
  - Part 2 Record Breach Tracking Number: Please supply your breach tracking number.
- No

CONTACT Information Screen

Please supply the required contact information for the breach.

- Are you a Part 2 program who experienced a breach of Part 2 records, and are filing on behalf of your own organization?
- Are you a Qualified Service Organization who experienced a breach of Part 2 records, and are filing on behalf of a Part 2 program?
- Are you a Part 2 program filing because your Qualified Service Organization experienced a breach of Part 2 records?

If "Are you a Part 2 Program who experienced a breach of Part 2 records, and are filing on

behalf of your organization**" was selected:**

Part 2 Program: Please provide the following information.

* Name of Part 2 Program: (Name of Program only (not of its representative), no abbreviations, no acronyms):

* Street Address Line 1:

Street Address Line 2:

* City:

* State: -- Choose State --

* ZIP:

Part 2 Program Point of Contact Information

* First Name:

* Last Name:

* Email:

* Phone Number: (Include area code):

* Usage

- Home/Cell
- Work

If "Are you a Qualified Service Organization who experienced a breach of Part 2 records, and are filing on behalf of a Part 2 Program**" was selected**

Qualified Service Organization: Completion of this section is required if the breach occurred at or by a Qualified Service Organization or if you are filing on behalf of a Part 2 Program.

* Name of Qualified Service Organization: (Name of Qualified Service Organization only (not of its representative), no abbreviations, no acronyms):

* Street Address Line 1:

Street Address Line 2:

* City:

* State: -- Choose State --

* ZIP:

Qualified Service Organization Point of Contact Information

* First Name:

* Last Name:

* Email:

* Phone Number: (Include area code):

* Usage

- Home/Cell
- Work

Enter the contact information for all Part 2 Programs on whose behalf you are filing.

Part 2 Program 1

* Name of Part 2 Program: (Name of Part 2 Program only (not of its representative), 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):

* Usage

- Home/Cell
- Work

If "Are you a Part 2 Program filing because your Qualified Service Organization experienced a breach of Part 2 records**" was selected:**

Part 2 Program: Please provide the following information.

* Name of Part 2 Program: (Name of Program only (not of its representative), no abbreviations, no acronyms):

* Street Address Line 1:

Street Address Line 2:

* City:

* State: -- Choose State –

* ZIP:

Part 2 Program Point of Contact Information

* First Name:

* Last Name:

* Email:

* Phone Number: (Include area code):

* Usage

- Home/Cell
- Work

Qualified Service Organization: Completion of this section is required if the breach occurred at or by a Qualified Service Organization.

* Name of Qualified Service Organization: (Name of Qualified Service Organization only, no abbreviations, no acronyms):

* Street Address Line 1:

Street Address Line 2:

* City:

* State: -- Choose State --

* ZIP:

Qualified Service Organization Point of Contact Information

* First Name:

* Last Name:

* Email:

* Phone Number: (Include area code):

* Usage
- Home/Cell
- Work

BREACH Information Screen

Breach Affecting: How many individuals are affected by the breach? ("Individuals" refers to patients of a Part 2 program when reporting a breach of such records).

- 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 (drop-down instructions available in the portal):

- □ Hacking/IT Incident Help
- □ Improper Disposal Help
- □ Loss Help
- □ Theft Help
- □ Unauthorized Use/Disclosure

* Location of Breach:

- □ Desktop Computer
- □ Electronic Record
- □ Email
- □ Laptop
- □ Network Server
- □ Other Portable Electronic Device
- □ Paper Records or Films
- □ Other

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* Type of Part 2 Record Involved in Breach:

☐ Indicate here if the Part 2 Record described above is also Protected Health Information

- □ Clinical
  - o Diagnosis/Conditions
  - o Lab Results
  - o Medications
  - o Other Treatment Information
- □ Demographic
  - o Address/ZIP
  - o Date of Birth
  - o Driver's License
  - o Name
  - o SSN
  - o Other Identifier
- □ Financial
  - o Claims Information

- Credit Card/Bank Acct #
- Other Financial Information

□ Other

* Type of Part 2 Record Involved in Breach (Other): [4,000

characters limit]

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* Brief Description of the Breach: [4,000 characters limit]

Do not provide any Part 2 records (*i.e.*, any patient identifying information) with this report.

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* Safeguards in Place Prior to Breach (select all that apply):

□ None
□ Part 2 Security for Records (Policies and Procedures)
□ Part 2 Disposition of Records by Discontinued Programs
□ HIPAA Privacy Rule Safeguards (Training, Policies and Procedures, etc.), if applicable, or similar safeguards
□ HIPAA Security Rule Administrative Safeguards (Risk Analysis, Risk Management, etc.), if applicable, or similar safeguards
□ HIPAA Security Rule Physical Safeguards (Facility Access Controls, Workstation Security, etc.), if applicable, or similar safeguards
□ HIPAA Security Rule Technical Safeguards (Access Controls, Transmission Security, etc.), if applicable, or similar safeguards

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NOTICE OF BREACH AND ACTIONS TAKEN Information Screen

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
  - 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 –
- No

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* Actions Taken in Response to Breach (select all that apply):

- □ Adopted encryption technologies
- □ Changed password/strengthened password requirements
- □ Created a new/updated security management plan
- □ Implemented new technical safeguards
- □ Implemented periodic technical and nontechnical evaluations
- □ Improved physical security
- □ Provided individuals with free credit monitoring
- □ Provided Qualified Service Organizations with additional training on Part 2
- □ Revised Qualified Service Organization agreements
- □ Sanctioned workforce members involved (including termination)
- □ Revised policies and procedures
- □ Performed a new/updated risk analysis for electronic records
- □ Took steps to mitigate harm
- □ Trained or retrained workforce members
- □ Other
  - * Describe Other Actions Taken: [4,000 characters limit]

HIPAA BREACH REPORT INFORMATION

Are you a HIPAA Covered Entity or Business Associate and the Part 2 record breach you reported involves Part 2 records that are protected health information?

- Yes / No

If Yes, have you filed a HIPAA Breach Report for the breach of protected health information?

- Yes / No

If Yes, please provide the HIPAA Breach Tracking Number: _____

If you do not recall the HIPAA Breach Tracking Number, please check here: [checkbox]

If No, you must file a separate HIPAA Breach Report for a breach of unsecured protected health information as required by the HIPAA Breach Notification Rule.

ATTESTATION Information Screen

Please complete the Attestation form.

Under the Freedom of Information Act (5 U.S.C. §552) and HHS regulations at 45 CFR 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 website 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. These provisions apply to Part 2 program reports of breaches of records protected by 42 U.S.C. 290dd-2 in the same manner as they apply to covered entities for breaches of unsecured protected health information. 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: [system generated]