



HIPAA BREACH NOTIFICATION CHECKLIST

CONFIDENTIAL

Program: _____ Date Completed: _____

Completed by: _____

| # | YES | NO | TYPE OF MEDIUM BREACHED |
|----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Computerized data (includes e-mails, faxes) |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Encrypted. |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Paper |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Oral |

| # | YES | NO | DATA ELEMENTS BREACHED |
|-----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Name of Individual(s). |
| 2. | | | If "Yes, to #1", please enter the number of individuals |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Postal Address Information |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Zip Code(s) |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Date(s) of Birth |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Telephone Number(s) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Fax Number(s) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Electronic Mail Address(es) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Social Security Number(s). |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Medical Record Number(s). |



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|-----|--------------------------|--------------------------|--|
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Health Plan Beneficiary Number(s). |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Account Number(s). |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Certificate/license number(s). |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Vehicle Identifier(s) and Serial Number(s), Including License Plate Number(s). |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Device Identifier(s) and Serial Number(s). |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Web Universal Resource Locator(s) (URLs) |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Internet Protocol (IP) Address Number(s). |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Biometric Identifiers, Including Finger and Voice Print(s). |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | Full Face Photographic Images and Any Comparable Image(s). |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Relates to the Past, Present, or Future Physical or Mental Health or Condition of an Individual. |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Relates to the Provision of Health Care to an Individual. |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | Relates to The Past, Present, or Future Payment for the Provision of Health Care to an Individual. |