McLaren HEALTH CARE		Policy Title:	HIPAA Privacy and Security Breaches, Notifications, and Mitigation
Effective Date:	January 18, 2011	**Policy Number:**	MHC_CC1109
Review Date:		**Section:**	Compliance
Revised Date:	March 12, 2024	**Oversight Level:**	Corporate
Administrative Responsibility:	Corporate VP of Compliance; HIPAA Council		

1. Purpose

1.1. This document sets forth the policy and procedures to comply with the HIPAA Rules Regarding Breaches of Protected Health Information.

2. Scope

2.1. McLaren Health Care Corporation ("MHC"), its subsidiaries, any other entity or organization in which MHC or an MHC subsidiary owns a direct or indirect equity interest of 50% or more, provided that organization has agreed to adopt MHC policies; and MHC's workforce members, including employees and contracted agents, physicians, volunteers, vendors/suppliers, and other business partners.

2.2. Business Associates of MHC and its subsidiaries, including organized health care arrangements in which they participate, as required by the HIPAA Rules.

3. Definitions

3.1. Breach means the acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted by the Privacy Rule which compromises the security or privacy of the PHI.

3.1.1. Breach excludes:

3.1.1.1. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by the HIPAA Rules.

3.1.1.2. Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or Business Associate to another person authorized to access PHI at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted by the Privacy Rule.

3.1.1.3. A disclosure of PHI where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

3.1.2. Except as provided in 3.1.1, an acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Rule is presumed to be a Breach unless

MHC or its Business Associate, as applicable, demonstrates that there is a low probability that the Protected Health Information has been compromised based on a Risk Assessment.

3.2. **Business Associate** means an organization or a person, other than a Workforce Member who:

3.2.1. On behalf of MHC, creates, receives, maintains, or transmits PHI for:

3.2.1.1. claims processing or administration; data analysis, processing or administration; utilization review; quality assurance; patient safety activities; billing; benefit management; practice management; and repricing; or

3.2.2. Provides one of the following services which involves the disclosure of PHI from MHC or another Business Associate:

3.2.2.1. legal; actuarial; accounting; consulting; data aggregation; management; administrative; accreditation; or financial services to MHC;

3.2.3. Provides data transmission services which routinely require access to PHI;

3.2.4. Provides personal health records to one or more Individuals on behalf of MHC;

3.2.5. Is a Subcontractor that creates, receives, maintains, or transmits PHI on behalf of the Business Associate;

3.2.6. Business Associate does not include:

3.2.6.1. Subsidiaries or other covered entities which are part of an MHC organized health care arrangement;

3.2.6.2. Government agencies that determine eligibility for a government health plan;

3.2.6.3. A plan sponsor making disclosures for its group health plan.

3.3. **Discovery or "Discovered"** is defined as the first day on which a Breach is known or, by exercising reasonable diligence, would have been known. MHC shall be deemed to have knowledge of a Breach if it is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of MHC.

3.4. **HIPAA Rules** means the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and implementing regulations, the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") the Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule"), Standards for Electronic Transactions, and the privacy, security and Breach Notification regulations of the Health Information Technology for Economic and Clinical Health Act ("HITECH Rules") and HIPAA Omnibus final rule.

3.5. **Individual** means the person who is the subject of PHI or the Authorized Representative acting on behalf of the Individual.

3.6. **Next of Kin** includes the following persons in order of priority:

3.6.1. Spouse

3.6.2. Adult Children

3.6.3. Mother or Father

3.6.4. Adult Siblings

3.6.5. Other persons authorized or obligated to provide care.

3.7. **Organized Health Care Arrangement (OHCA)** is an organized system of health care where the various components of the Corporation hold themselves out to the public as participating in a joint arrangement, and jointly perform treatment, payment, and/or operations including utilization review and quality assessment and improvement activities; and one or more group health plans maintained by the same plan sponsor; and the Board of Directors of the Corporation has determined that the creation of an "Organized Health Care Arrangement," as defined in 45 C.F.R. §164.501, would permit the components of the Corporation to perform services for their patients and plan participants more efficiently and effectively.

3.8. **Personal Representative** (Authorized Representative) is defined as the person who has the authority, granted by the Probate Court, to act on behalf of a Deceased Individual or the Individual's estate.

3.9. **Protected Health Information (PHI) and/or Patient Record** is defined as any Individually identifiable health information that is collected from an Individual, and is transmitted, received, created and/or maintained, in any form or medium, by MHC and/or its subsidiaries.

3.9.1. PHI is any information that:

3.9.1.1. Relates to the past, present or future physical or mental health/condition of an Individual.

3.9.1.2. Relates to the provision of health care to an Individual.

3.9.1.3. Relates to the past, present, or future payment for the provision of health care to an Individual.

3.9.2. PHI is any information that either identifies the Individual or there is a reasonable basis to believe the information can be used to identify the Individual. Examples include, but are not limited to:

3.9.2.1. name, medical record number, encounter number, social security number, address, and photo, diagnosis, diagnostic reports, procedures, progress notes, images, medications, billing documents, physician or location (if such information leads one to know or infer a diagnosis, etc.), slides, and/or blocks.

3.9.3. PHI excludes:

3.9.3.1. Records of students maintained by federally funded educational agencies: covered by the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g; or maintained by a healthcare provider and used only for the treatment of students 18 years or older, or attending post-secondary educational institutions, 20 U.S.C. 1232g(a)(4)(B)(iv);

3.9.3.2. Employment records held by MHC in its role as employer; and

3.9.3.3. Records of a person who has been deceased more than 50 years.

3.10. **Risk Assessment** means a review of at least the following factors:

3.10.1. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

3.10.2. The unauthorized person who used the PHI or to whom the disclosure was made;

3.10.3. Whether the PHI was actually acquired or viewed; and

3.10.4. The extent to which the risk to the PHI has been mitigated.

3.11. **Secretary** means the Secretary of Health and Human Services.

3.12. **Subcontractor** is a person to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such Business Associate.

3.13. **Unsecured PHI** is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized person(s) through the use of a technology or methodology specified by the Secretary in guidance if one or more of the following applies:

3.13.1. Electronic PHI has been encrypted as specified in the HIPAA Security Rule by "the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key" (45 CFR 164.304 definition of encryption) and such confidential process or key that might enable decryption has not been Breached. To avoid a breach of the confidential process or key, these decryption tools should be stored on a device or at a location separate from the data they are used to encrypt or decrypt. The encryption processes identified below have been tested by the National Institute of Standards and Technology (NIST) and judged to meet this standard.

3.13.1.1. Valid encryption processes for data at rest are consistent with NIST Special Publication 800-111, Guide to Storage Encryption Technologies for End User Devices.

3.13.1.2. Valid encryption processes for data in motion are those which comply, as appropriate, with NIST Special Publications 800-52 and amendments, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS) 140-2 validated.

3.13.2. The media on which the PHI is stored or recorded has been destroyed in one of the following ways:

3.13.2.1. Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.

3.13.2.2. Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI cannot be retrieved.

3.14. **Workforce / Workforce Members** is defined as employees, temporary workers, contracted agents, physicians, volunteers, vendors/suppliers, consultants, students and other persons or entities whose conduct in the performance of work is under the direct control of MHC or its Business Associate, whether or not they are paid by MHC or its Business Associate.

4. Policy

4.1. **Breach Notification Requirements.** The Compliance Officer or Corporate Vice President of Compliance must be notified of any actual or potential Breach of Unsecured PHI, immediately upon Discovery.

4.2. **Risk Assessment**. MHC will conduct a Risk Assessment for each actual or potential Breach and document findings in the Breach Risk Assessment Tool (Appendix 7.3).

4.2.1. MHC has the burden of proof to demonstrate that all required notifications have been provided or that a use or disclosure of Unsecured PHI did not constitute a Breach.

4.3. **Notification.** Unless the Compliance Officer, or designee, determines, based on the Risk Assessment, that there is a "low probability" that the PHI has been compromised, MHC must provide notification of the Breach to affected Individuals, the Secretary, and, in certain circumstances, the media. In addition, Business Associates must notify MHC that a Breach has occurred.

4.3.1. *Notice to Individuals*. MHC must notify affected Individuals following the Discovery of a Breach of Unsecured PHI.

4.3.1.1. MHC must provide the Individuals notice in written form by first-class mail, or alternatively, by Email if the affected Individual has agreed to receive such notices electronically. The notice must be written in plain language.

4.3.1.2. If the Individual is deceased and MHC has the address of the Next of Kin or Personal Representative, written notice by first-class mail to the Next of Kin or Personal Representative of the Individual. Substitute notice is not required in the case in which there is insufficient or out-of-date contact information that precludes written notification to the Next of Kin or Personal Representative of an Individual.

4.3.1.3. If MHC has insufficient or out-of-date contact information for 10 or more Individuals, including deceased Individuals, MHC must provide substitute notice by either posting the notice on the home page of its web site or by providing the notice in major print or broadcast media where the affected Individuals likely reside. The substitute notice shall:

4.3.1.3.1. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the website of the MHC entity involved, or conspicuous notice in major print or broadcast media in geographic areas where the Individuals affected by the Breach likely preside; and

4.3.1.3.2. Include a toll-free phone number that remains active for at least 90 days where an Individual can learn whether the Individual's Unsecured PHI may be included in the Breach.

4.3.1.4. If MHC has insufficient or out-of-date contact information for fewer than 10 Individuals, MHC may provide substitute notice by an alternative form of written notice, telephone, or other means.

4.3.1.5. Additional Notice in Urgent Situations. In any case deemed by MHC to require urgency because of possible imminent misuse of Unsecured PHI, the information may be provided to the Individuals by telephone or other means, as appropriate, in addition to the required written notice.

4.3.1.6. Timing and Content of Notice. Individual notifications must be provided without unreasonable delay and in no case later than 60 calendar days following the Discovery of a Breach and must include, to the extent possible:

4.3.1.6.1. a brief description of the Breach, including the date of the Breach, and the date of the Discovery of the Breach;

4.3.1.6.2. a description of the types of Unsecured PHI that was involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

4.3.1.6.3. the steps affected Individuals should take to protect themselves from potential harm;

4.3.1.6.4. a brief description of what the covered entity is doing to investigate the Breach, to mitigate harm to Individuals, and prevent further Breaches; and

4.3.1.6.5. Contact information of the entity Privacy Officer; including a toll-free number, an Email address, Website, or postal address for Individuals to ask questions or learn additional information.

4.3.2. *Notice to the Media*. If MHC experiences a Breach affecting more than 500 residents of a State or jurisdiction, in addition to notifying the affected Individuals, MHC is required to provide notice to prominent media outlets serving the State or jurisdiction.

4.3.2.1. MHC will likely provide this notification in the form of a press release to appropriate media outlets serving the affected area. Like Individual notice, this media notification must be provided without unreasonable delay and in no case later than 60 calendar days following the Discovery of a Breach and must include the same information required for the Individual notice.

4.3.3. *Notice to the Secretary*. MHC will notify the Secretary by visiting the HHS Website and filling out and electronically submitting a Breach report form.

4.3.3.1. If a Breach affects 500 or more Individuals, MHC must notify the Secretary without unreasonable delay and in no case later than 60 calendar days following the Breach.

4.3.3.2. If a Breach affects fewer than 500 Individuals, MHC may notify the Secretary of such Breaches without unreasonable delay following the conclusion of the investigation, but no later than 60 days after the end of the calendar year in which the Breach was discovered.

4.3.4. For McLaren Central Michigan only – As required under SANE Grant terms, the Michigan Division of Victim Services will be notified within 24 hours of a breach of PHI/PII relating to any patient treated by a Sexual Assault Nurse Examiner.

4.4. Notification of a Breach by a Business Associate or a Business Associate's Subcontractor. If a Breach of Unsecured PHI occurs at or by a Business Associate, or a Subcontractor of the Business Associate, the Business Associate must notify MHC immediately following the Discovery of the Breach and at a minimum within five (5) business days, unless otherwise specified in the Business Associate Agreement. See MHC_CC1106 Business Associate and Data Use Agreements for detail.

4.4.1. *Breach Information*. The Business Associate must provide MHC with:

4.4.1.1. the identification of each Individual affected by the Breach as well as:

4.4.1.2. a complete description of the Breach, including the date of the Breach, and the date of the Discovery of the Breach; and

4.4.1.3. a description of the types of Unsecured PHI that was involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved) .

4.4.2. *Notification*. At MHC's option, or as specified in the Business Associate Agreement, the Business Associate will notify Individuals under the direction of MHC Privacy Officer or designee, or cover the associated costs incurred by MHC if MHC provides notice to Individuals.

4.4.3. *Mitigation*. In accordance with the Business Associate Agreement the Business Associate will be responsible to mitigate to the extent practicable the Breach to the Individual(s).

4.4.4. *Remediation*. The Business Associate will provide MHC with an analysis of causes, a plan of correction and provide periodic reports on remediation progress.

4.5. Law Enforcement Delay. If a law enforcement official states to MHC or Business Associate that a notification, notice, or posting required by this Policy would impede a criminal investigation or cause damage to national security, MHC or its Business Associate shall:

4.5.1. If the statement is in writing and specifies the time for which the delay is required, delay such notification, notice, or posting for the time period specified by the official; or

4.5.2. If the statement is made orally, document the statement, including the identity of the official making the statement, and delay notification, notice or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement is submitted during that time.

4.6. Institutional Actions. At least annually, the Corporate HIPAA Council will review all incidents of actual or potential Breaches and make recommendations to the MHC Corporate Compliance Committee regarding institutional improvements required to minimize such occurrences in the future and to identify any changes in risk.

5. Procedure

5.1. Breach Notice Procedures. Once the Risk Assessment process is complete and it is determined by the Compliance or Privacy Officer that a Breach of Unsecured PHI has occurred, MHC must provide notification to the Individuals, to the Secretary, and as defined by the Policy to the media.

5.1.1. The Compliance or Privacy Officer will also immediately report the breach to the MHC Vice President of Compliance, who will notify the Risk and Insurance Department if the breach involves a data breach or cybersecurity concern so the cyber liability carrier can be notified when appropriate.

5.2. Notification. The Compliance or Privacy Officer will determine whether the breach requires reporting to the Individual, Secretary, and/or media based on the Risk Assessment process.

5.2.1. *Notice to the Individuals*. The Privacy Officer will provide Notice to Individuals without unreasonable delay and in no case later than 60 calendar days from the first day on which such Breach is Discovered.

5.2.1.1. The notice will be provided as required by this policy.

5.2.1.2. The notice will be written in plain language and must contain the information as described in Section 4.3.

5.2.2. *Credit Monitoring Provisions*:

5.2.2.1. The Privacy Officer will determine the need for up to one year of credit monitoring based on the outcome of the Risk Assessment. Refer to MHC_CC1109.7.4.)

5.2.2.2. The administrative approval process is required for greater than one year of credit monitoring.

5.2.3. *Media Notice*. If MHC experiences a Breach affecting more than 500 Individuals, the Privacy Officer, under the guidance of the Marketing and Communications Department, will provide notice to prominent media outlets serving the State or jurisdiction. The Notice will be provided in the form of a press release. Media notification must be provided without unreasonable delay and in no case later than 60 calendar days following the discovery of a Breach and must include the same information required for the Individual notice.

5.2.4. *Notice to the Secretary*. This notice must be submitted electronically by the Privacy Officer completing all information required on the online Breach notification form available at https://ocrportal.hhs.gov/ocr/breach (see appendix).

5.2.4.1. For Breaches that affect fewer than 500 Individuals, the Privacy Officer must provide the Secretary with notice. All notifications of Breaches must be submitted at the conclusion of the investigation, but no later than 60 days from the end of the calendar year in which the Breach occurred. This notice must be submitted electronically by following the link above and completing all information required on the Breach notification form. A separate form must be completed for every Breach

that has occurred during the calendar year.

5.2.4.2. If a Breach affects 500 or more Individuals, the Privacy Officer must provide the Secretary with notice of the Breach without unreasonable delay and in no case later than 60 calendar days from discovery of the Breach. This notice must be submitted electronically by following the link above and completing all information required on the Breach notification form.

5.2.4.3. If the Privacy Officer has submitted a Breach notification form to the Secretary and discovers additional information to report, he/she must submit an additional form, checking the appropriate box to signal that it is an updated submission.

5.3. Notification of a Breach by a Business Associate. The MHC Privacy Officer will obtain from the Business Associate the information as described in Section 4.4. The Business Associate may complete the Breach Notification Risk Assessment Tool (MHC_CC1109.7.3b) to provide the necessary information to MHC.

5.3.1. The MHC Privacy Officer will direct and oversee provision of notice to the Individuals if provided by the Business Associate, or provide the notice to the Individuals.

5.3.1.1. If providing notice, the Business Associate has the burden of proof to demonstrate that all required notifications have been provided.

5.3.2. The Privacy Officer will work with the Business Associate to determine that the Breach is mitigated to the extent practicable.

5.4. Law Enforcement Delay. The Privacy Officer will assure that they, or the Business Associate, abide with Section 4.5.

5.5. Institutional Actions. Each Compliance or Privacy Officer will report all substantial Breach incidents as soon as practicable to the Corporate Vice President of Compliance and the MHC Chief Information Security Officer. All actual or potential breach incidents will be reported in the MHC quarterly compliance report.

5.5.1. MHC has the burden of proof to demonstrate that all required notifications have been provided or that a use or disclosure of Unsecured PHI did not constitute a Breach. In order to demonstrate this evidence, the Privacy Officer will track all actual or potential Breach investigations, including Breaches by Business Associates, in Comply Track or similar tracking software as approved by the MHC Corporate Vice President of Compliance.

6. References

6.1. 45 CFR Parts 160 and 164

6.2. MCL 445.72 - IDENTITY THEFT PROTECTION ACT 452 of 2004, Notice of Security Breach, Requirements

6.3. Title XIII of the American Recovery and Reinvestment Act (ARRA), subtitled: Health Information Technology for Economic and Clinical Health Act (HITECH), including Subpart D – Privacy

6.4. MHC CC_0110 Record Retention Policy

6.5. MHC CC_0114 Non-Retaliation

6.6. MHC CC_0118 Identity Theft Prevention Program

6.7. MHC CC_1104 Joint Notice of Privacy Practices

6.8. MHC CC_1106 Business Associates

6.9. Notification to McLaren about a Security Incident and/or Breach of Unsecured Protected Health Information Form MHC_CC1106.7.4

6.10. CP 0105 Confidentiality in Mental Health Services

7. Appendix

7.1. Breach Discovery and Reporting Process

7.2. Breach Notification Decision Tree

7.3. a) MHC Breach Risk Assessment Tool; b) Business Associate Breach Risk Assessment Tool

7.4. Individual Notice Template - Sample

7.5. Media Notice Template

7.6. Notice to the Secretary Sample (must be completed online)

Previous Revisions: January 18, 2011, November 17, 2011, September 19, 2013, May 21, 2015, November 13, 2017, July 22, 2019

Supersedes Policy: Not Applicable

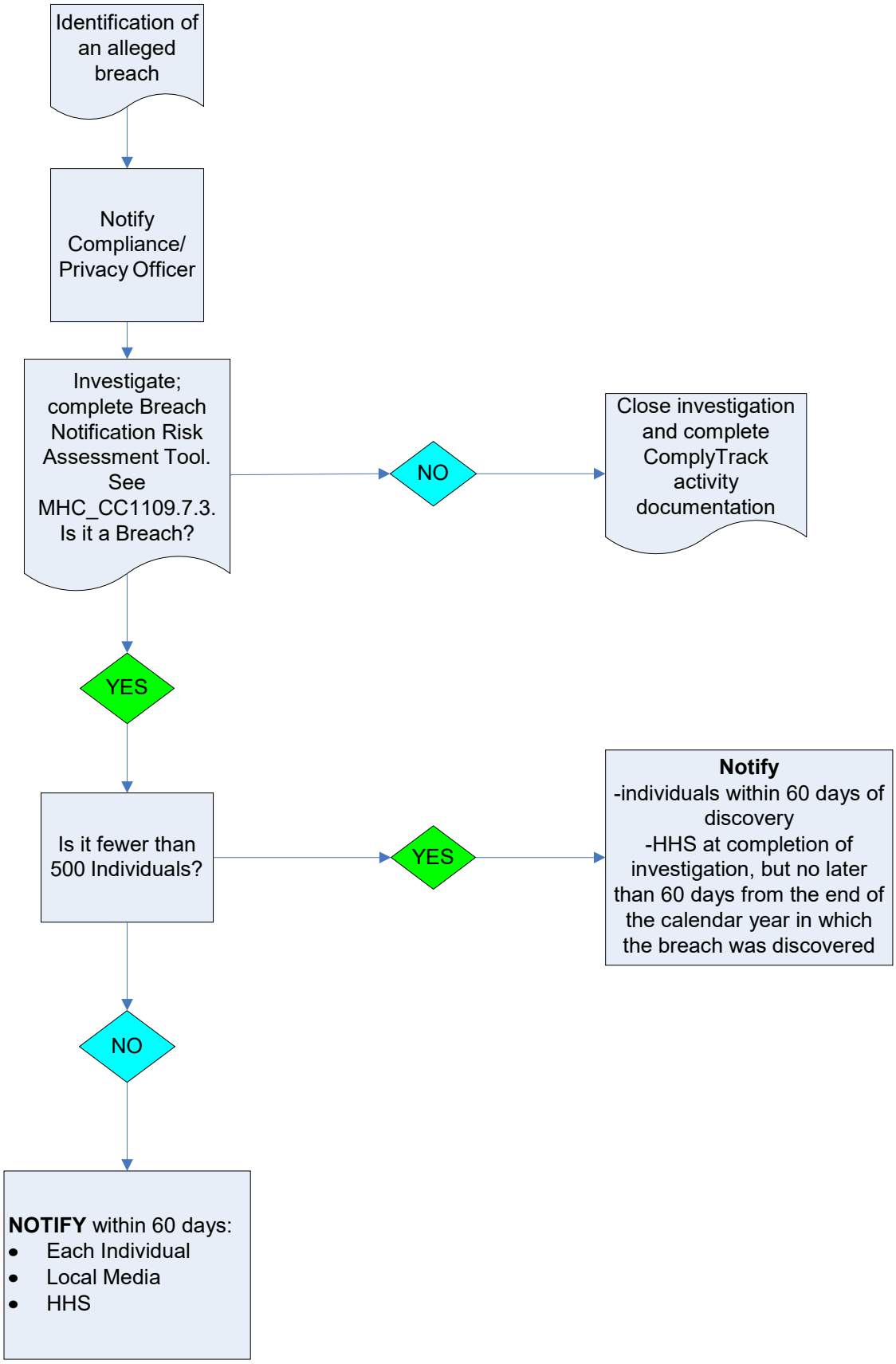
Approvals:

HIPAA Council: December 1, 2010, August 3, 2011, March 5, 2014, May 6, 2015, October 4, 2017, July 10, 2019, June 3, 2020, June 16, 2021, January 5, 2022, June 6, 2023, March 6, 2024

Corporate Compliance Committee: January 18, 2011, November 17, 2011, September 19, 2013, March 20, 2014, May 21, 2015, November 13, 2017, July 22, 2019, June 15, 2020, July 20, 2021, January 11, 2022, July 11, 2023, March 12, 2024

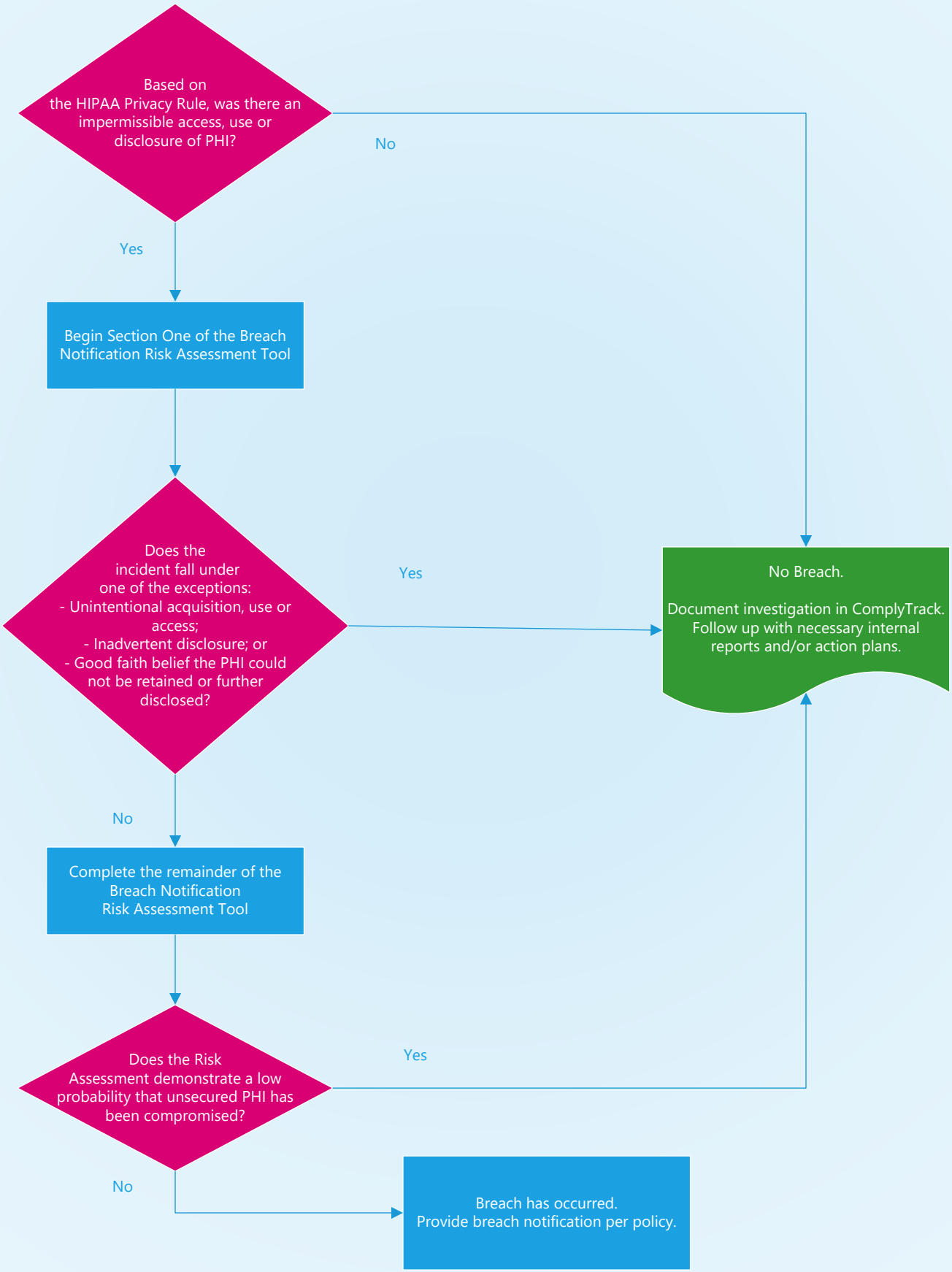
Signature on File 3/12/2024
Gregory R. Lane Date
Sr. VP and Chief Administrative Officer

Breach Discovery and Reporting Process



MHC_CC1109.7.2
Revised 6.12.19

BREACH NOTIFICATION DECISION TREE



McLaren Health Care
Breach Notification Risk Assessment Tool

Incident/Name	**Date of Discovery:**
Number of individuals effected by the breach and/or security incident (please attach a list to identify the individuals):	**Email Address of Reporter:**
Incident Reported By (Name/Title):	**Phone # of Reporter:**

Type of Incident: Please specify the type of privacy and/or security incident that occurred and details of the PHI involved below.	**Check all that apply:** ☐ **Inappropriate Access of PHI** ☐ **Inappropriate Disclosure of PHI** ☐ **Inappropriate Use of PHI**
Source of Incident: Who was responsible for the inappropriate access, use or disclosure?	☐ **Workforce Member** ☐ **Business Associate** ☐ **Business Associate Subcontractor** ☐ **Other Authorized User** ☐ **Other Unauthorized User (ex: theft, hacker)**
Notification by Business Associate or Business Associate Subcontractor (Business Associate made us aware of incident) • Who is the BA/Contractor? • Is there an executed agreement in place with the BA/Contractor that includes HIPAA provisions (such as a Business Associate Agreement)? • When did the BA/Contractor notify the McLaren of the incident? • How was the McLaren notified of the incident?	**BA Contact Name:** **Contact Email:** **Contact Phone:** **Date Notified by BA:** **Date BA Discovered:**
Are we the Business Associate? Enter the date that our organization became aware of the incident If we are the Business Associate, enter the date we notified the other Covered Entity of the incident	☐ **Yes** ☐ **Not Applicable** **Date of Discovery:** **Date Covered Entity Notified:**

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--- Section 1 ---	
1. Was data properly secured (e.g., encrypted, or secured as specified in NIST guidance) or properly destroyed (shredded) in compliance with the requirements in the Breach Notification Rule? OR Was the use/disclosure 'incidental to' a permitted disclosure (limited in scope and cannot reasonably be prevented)? ***If Yes, then STOP here. No breach has occurred that requires notification.*** ***If No, then proceed to next question.***	☐ **YES** ☐ **NO**
2. Does this incident qualify as one of the following exceptions? Check any that apply. **a. Good faith, unintentional acquisition/access/use/disclosure of PHI by a Workforce Member** **b. Inadvertent disclosure to another authorized person within the entity or OHCA** **c. Recipient could not reasonably have retained the data** ***If any checked, then STOP here. No breach has occurred that requires notification.*** ***If none apply, proceed to next section to continue the assessment and determine if the breach poses more than a low probability of data compromise, to the extent that it would require breach notification.***	☐ ☐ ☐

If you did not hit a STOP above in Section 1, then work through the rest of the assessment to determine if the *breach poses more than a low probability of data compromise to the extent that it would require breach notification.*

Go to Section 2

Check **all that apply** in each subsection and use highest applicable score:

--- Section 2 ---		
Variable	**Options**	**Score**
I. Method of Disclosure	☐ No evidence that data was accessed or disclosed	**0**
	☐ Unauthorized internal acquisition, access and/or use without disclosure outside of organization	**1**
	☐ Verbal Disclosure ☐ View only	**2**
	☐ Paper / Fax ☐ Electronic (email, mobile media, archive media, PC, server, etc.)	**3**
II. Amount of Data	☐ No data accessed or disclosed	**0**
	☐ Small amount – e.g., demographic information; limited data set; 1-10 individuals	**1**
	☐ Moderate volume – 11-100; portions of records; a bill or EOB with coded information	**2**
	☐ Large volume – over 100; unknown volume; archive or mobile media or device compromised; entire record, database with multiple fields of data	**3**

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--- Section 2 ---

Variable	Options	Score
III. Nature and Extent of PHI Involved	☐ **No Data Acquired or Viewed**	**0**
	☐ **Limited or Demographic Data Only** Limited Data Set *(evaluate possibility of re-identification if ZIP Code and/or DOB included)* Only identifiers breached are not defined under MI Identity Theft Protection Act, and no other health information is breached: name, address, city, state, telephone number, fax number, e-mail address, admission/discharge dates, service dates, date of death	**1**
	☐ **General PHI** Information about treatment, diagnosis, service, medication, etc.	**2**
	☐ **Financial Data and/or Personal Identifiers** • Information defined by the MI Identity Theft Protection Act which includes the person's first name or first initial and last name in combination with any of the following: • Social security or employer taxpayer identification numbers • Driver's license, State identification card, or passport numbers • Checking account numbers • Savings account numbers • Credit card numbers • Debit card numbers • Personal Identification (PIN) Code as defined in G.S. 14-113.8(6) • Any other numbers or information that can be used to access a person's financial resources • Passwords-if the information would provide access to financial information or resources • Sensitive Protected Health Information which may include information about sensitive diagnosis such as HIV, Substance Abuse, and/or Mental Health	**3**
	Specify the Type(s) of Information Accessed or Disclosed:	

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Breach Notification Risk Assessment Tool

--- Section 2 ---

Variable	Options	Score
IV. Who Received or Accessed the PHI	☐ Not applicable	**0**
	☐ A member of MHC Workforce ☐ Business Associate/Business Associate subcontractor ☐ Business Associate/Subcontractor Workforce ☐ Another Covered Entity	**1**
	☐ Wrong Payor (not the patient's) ☐ Unauthorized family member ☐ Non-healthcare organization ☐ Government agency	**2**
	☐ Media ☐ Unknown/Lost/Stolen ☐ Member of the general public	**3**
V. Circumstances of release	☐ Unintentional access to or disclosure of PHI	**1**
	☐ Lost or unable to determine whether compromise was likely	**2**
	☐ Intentional disclosure w/o authorization ☐ Intentional acquisition/use/access w/o authorization using false pretense to obtain or disclose ☐ Obtained for personal gain/malicious harm ☐ Hack ☐ Theft – Device targeted or Data targeted	**3**
VI. Disposition/ Mitigation (What happened to the information after the initial disclosure)	☐ Visual- viewed only with no further disclosure ☐ Information returned complete ☐ Information properly destroyed and attested to by workforce member, another covered entity or business associate ☐ Data Wiped by remote application ☐ Forensic analysis found no information accessed	**1**
	☐ Information properly destroyed (outside organization/individual) ☐ Information/Device is encrypted or protected with proprietary software, but does not meet compliance with NIST Standards ☐ Information Destroyed, but does not meet compliance with NIST Standards ☐ Password protected – password not compromised or unknown if password compromised	**2**
	☐ Password protected – password was compromised ☐ Data not encrypted, readable, but archived in a block format in no relational order. Password and proprietary system NOT required to view data. ☐ No known controls ☐ Unable to mitigate ☐ Unable to retrieve data ☐ Unsure of disposition or location ☐ Suspicion of pending re-disclosure ☐ PHI already re-disclosed [Continued on next page]	**3**

	☐ Sent to the Media	

SCORING

Total Probability of Compromise Score *(Section 2)*	

The scoring is meant to serve as a guide in your decision making and not designed to make the decision for you. There are a variety of factors and mitigations that may be involved in your incident that this tool cannot foresee or predict. An attempt was made to develop this is a way that would help you in documenting your actions, consider factors and circumstances and then aid in your final decision of making a breach notification or not making a breach notification.

Probability of Compromise

Low **High**

◄——————————————————►

0 9 18

Additional information and basis for decision:	**Final Decision**	
	Low Probability of Compromise	☐
	Breach Requiring Notice	☐

Resolution and Corrective Action(s) (actions taken to prevent recurrence, responsible individual(s), and target dates for completion):

☐ Corrected system issues (e.g., disabled auto-faxing, updated system with correct information, etc.)
☐ Reviewed user security access levels for appropriateness and identified required changes
☐ Changed or updated policies/procedures
☐ Discussed results with leader(s) and identified changes to improve process or prevent reoccurrence
☐ Counseled/educated to person or staff members to assure they understand what they did was wrong
☐ Retrieved PHI or documented recipient's assurances that PHI was destroyed or not further disclosed

Document in detail all the above corrective actions in ComplyTrack.

Complete this section if breach notification is required:
Date of Notice to Individual(s):
Credit monitoring offered to individual:
Date of Notice to Secretary HHS:

_____ _____

Individual completing Risk Assessment **Date**

McLaren Health Care
Business Associate Breach Notification Risk Assessment Tool

Incident/Name	**Date of Discovery:**
Number of individuals effected by the breach and/or security incident (please attach a list to identify the individuals):	**Email Address of Reporter:**
Incident Reported By (Name/Title):	**Phone # of Reporter:**

Type of Incident: Please specify the type of privacy and/or security incident that occurred and details of the PHI involved below.	**Check all that apply:** ☐ **Inappropriate Access of PHI** ☐ **Inappropriate Disclosure of PHI** ☐ **Inappropriate Use of PHI**
Source of Incident: Who was responsible for the inappropriate access, use or disclosure?	☐ **Business Associate Workforce Member** ☐ **Business Associate Subcontractor** ☐ **Other Unauthorized User (ex: theft, hacker)**
Notification by Business Associate or Business Associate Subcontractor (Business Associate made us aware of incident) • Who is the BA/Contractor? • Is there an executed agreement in place with the BA/Contractor that includes HIPAA provisions (such as a Business Associate Agreement)? • When did the BA/Contractor notify the McLaren of the incident? • How was the McLaren notified of the incident?	**BA Contact Name:** **Contact Email:** **Contact Phone:** **Date BA Notified MHC:** **Date BA Discovered Incident:**

McLaren Health Care
Business Associate Breach Notification Risk Assessment Tool

--- Section 1 ---

[Section Removed]	
1. Was data properly secured (e.g., encrypted, or secured as specified in NIST guidance) or properly destroyed (shredded) in compliance with the requirements in the Breach Notification Rule? OR Was the use/disclosure 'incidental to' a permitted disclosure (limited in scope and cannot reasonably be prevented)? ***If Yes, then STOP here. No breach has occurred that requires notification.*** ***If No, then proceed to next question.***	☐ **YES** ☐ **NO**
2. Does this incident qualify as one of the following exceptions? Check any that apply. **a. Good faith, unintentional acquisition/access/use/disclosure of PHI by a Workforce Member** **b. Inadvertent disclosure to another authorized person within the entity or OHCA** **c. Recipient could not reasonably have retained the data** ***If any checked, then STOP here. No breach has occurred that requires notification.*** ***If none apply, proceed to next section to continue the assessment and determine if the breach poses more than a low probability of data compromise, to the extent that it would require breach notification.***	☐ ☐ ☐

If you did not hit a STOP above in Section 1, then work through the rest of the assessment to determine if the *breach poses more than a low probability of data compromise to the extent that it would require breach notification.*

Go to Section 2

Check **all that apply** in each subsection and use highest applicable score:

--- Section 2 ---

Variable	Options	Score
I. Method of Disclosure	☐ No evidence that data was accessed or disclosed ☐ Attestation received that information was not further used or disclosed	**0**
	☐ Unauthorized internal acquisition, access and/or use without disclosure outside of organization	**1**
	☐ Verbal Disclosure ☐ View only	**2**
	☐ Paper / Fax ☐ Electronic (email, mobile media, archive media, PC, server, etc.)	**3**
II. Amount of Data	☐ No data accessed or disclosed	**0**
	☐ Small amount – e.g., demographic information; limited data set; 1-10 individuals	**1**
	☐ Moderate volume – 11-100; portions of records; a bill or EOB with coded information	**2**
	☐ Large volume – over 100; unknown volume; archive or mobile media or device compromised; entire record, database with multiple fields of data	**3**

McLaren Health Care
Business Associate Breach Notification Risk Assessment Tool

--- Section 2 ---

Variable	Options	Score
III. Nature and Extent of PHI Involved	☐ **No Data Acquired or Viewed**	**0**
	☐ **Limited or Demographic Data Only** Limited Data Set *(evaluate possibility of re-identification if ZIP Code and/or DOB included)* Only identifiers breached are not defined under MI Identity Theft Protection Act, and no other health information is breached: name, address, city, state, telephone number, fax number, e-mail address, admission/discharge dates, service dates, date of death	**1**
	☐ **General PHI** Information about treatment, diagnosis, service, medication, etc.	**2**
	☐ **Financial Data and/or Personal Identifiers** • Information defined by the MI Identity Theft Protection Act which includes the person's first name or first initial and last name in combination with any of the following: • Social security or employer taxpayer identification numbers • Driver's license, State identification card, or passport numbers • Checking account numbers • Savings account numbers • Credit card numbers • Debit card numbers • Personal Identification (PIN) Code as defined in G.S. 14-113.8(6) • Any other numbers or information that can be used to access a person's financial resources • Passwords-if the information would provide access to financial information or resources • Sensitive Protected Health Information which may include information about sensitive diagnosis such as HIV, Substance Abuse, and/or Mental Health	**3**
	Specify the Type(s) of Information Accessed or Disclosed:	

McLaren Health Care
Business Associate Breach Notification Risk Assessment Tool

--- Section 2 ---

Variable	Options	Score
IV. Who Received or Accessed the PHI	☐ Not applicable	**0**
	☐ A member of MHC Workforce ☐ Business Associate/Business Associate subcontractor ☐ Business Associate/Subcontractor Workforce ☐ Another Covered Entity	**1**
	☐ Wrong Payor (not the patient's) ☐ Unauthorized family member ☐ Non-healthcare organization ☐ Government agency	**2**
	☐ Media ☐ Unknown/Lost/Stolen ☐ Member of the general public	**3**
V. Circumstances of release	☐ Unintentional access to or disclosure of PHI	**1**
	☐ Lost or unable to determine whether compromise was likely	**2**
	☐ Intentional disclosure w/o authorization ☐ Intentional acquisition/use/access w/o authorization using false pretense to obtain or disclose ☐ Obtained for personal gain/malicious harm ☐ Hack ☐ Theft – Device targeted or Data targeted	**3**
VI. Disposition/ Mitigation (What happened to the information after the initial disclosure)	☐ Visual- viewed only with no further disclosure ☐ Information returned complete ☐ Information properly destroyed and attested to by workforce member, another covered entity or business associate ☐ Data Wiped by remote application ☐ Forensic analysis found no information accessed	**1**
	☐ Information properly destroyed (outside organization/individual) ☐ Information/Device is encrypted or protected with proprietary software, but does not meet compliance with NIST Standards ☐ Information Destroyed, but does not meet compliance with NIST Standards ☐ Password protected – password not compromised or unknown if password compromised	**2**
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Total Probability of Compromise Score *(Section 2)*	

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Probability of Compromise

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Additional information and basis for decision:	**Final Decision**	
	Low Probability of Compromise	☐
	Breach Requiring Notice	☐

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Complete this section if breach notification is required:
Date of Notice to Individual(s):
Credit monitoring offered to individual:
Date of Notice to Secretary HHS:

_____ _____

Individual completing Risk Assessment **Date**

Logo/McLaren Health Care Corporation
<<Return Address>>
<<City>>, <<State>> <<Zip>>

To Enroll, Please Visit:
https://app.idx.us/account-creation/protect
Enrollment Code: <<XXXXXXXX>>

<<First Name>> <<Last Name>>
<<Address1>> <<Address2>>
<<City>>, <<State>> <<Zip>>

<<Date>>

Notice of Data Breach

Dear <<First Name>> <<Last Name>>,

What Happened

McLaren Health Care Corporation has discovered that [please include date(s) of incident and when it was discovered] In addition, in [California specify if notification was delayed as a result of a law enforcement investigation.] [If Rhode Island residents, specify number of affected individuals.]

Examples:
1) On August 1, 2015, we discovered that a group of files containing confidential information were inadvertently placed on a web server on July 15, 2015. The information was removed immediately upon discovery, and at this time, there is no evidence to suggest that there has been any attempt to misuse any of the information.
2) This letter is written to inform you, that on July 1st, 2015 we became aware of an employee who accessed your account information without a direct business need. The account information pertained to services provided to you on and the access was not necessary for the employee to perform or complete their job assignment. We believe the improper access occurred between the dates of September 2014 and July 2015.

What Information Was Involved

Examples:
1) The account information included name, date of birth, home address, phone number, account number and admit reason
2) The compromised information was comprised of protected health information including the patient's first and last name, date of birth, medications, residential unit and in some cases the patient's diagnosis.

What We Are Doing

We are working to [improve security, mitigate risk, etc; general acts to protect from further unauthorized access. (For PR- an estimate of the time and cost required to rectify the situation.)

Examples:
1) We have implemented additional safeguards to improve data security on our web server infrastructure.
2) We are taking additional steps to protect patient related data from theft or similar criminal activity in the future. We are ensuring that all personally assigned portable computers utilize encryption software for patient data protection.

In addition, we are offering identity theft protection services through IDX, the data breach and recovery services expert. IDX identity protection services include: 12 months of credit and CyberScan monitoring, a $1,000,000 insurance reimbursement policy, and fully managed id theft recovery services. With this protection, IDX will help you resolve issues if your identity is compromised.

What You Can Do

We encourage you to enroll in free IDX identity protection services by going to https://app.idx.us/account-creation/protect or calling 1-800-939-4170 and using the Enrollment Code provided above. IDX representatives are available Monday through Friday from 6 am - 6 pm Pacific Time. Please note the deadline to enroll is September 13, 2023.

Again, at this time, there is no evidence that your information has been misused. However, we encourage you to take full advantage of this service offering.

For More Information

You will find detailed instructions for enrollment on the enclosed Recommended Steps document. Also, you will need to reference the enrollment code at the top of this letter when enrolling, so please do not discard this letter.

Sincerely,

Name
McLaren Health Care Corporation

(Enclosure)

Recommended Steps to Help Protect Your Information

1. **Website and Enrollment.** Go to https://app.idx.us/account-creation/protect and follow the instructions for enrollment using your Enrollment Code provided at the top of the letter.

2. Activate the credit monitoring provided as part of your IDX identity protection membership. The monitoring included in the membership must be activated to be effective. Note: You must have established credit and access to a computer and the internet to use this service. If you need assistance, IDX will be able to assist you.

3. Review your credit reports. We recommend that you remain vigilant by reviewing account statements and monitoring credit reports. Under federal law, you also are entitled every 12 months to one free copy of your credit report from each of the three major credit reporting companies. To obtain a free annual credit report, go to www.annualcreditreport.com or call 1-877-322-8228. You may wish to stagger your requests so that you receive a free report by one of the three credit bureaus every four months.

If you discover any suspicious items and have enrolled in IDX identity protection, notify them immediately by calling or by logging into the IDX website and filing a request for help.

If you file a request for help or report suspicious activity, you will be contacted by a member of our ID Care team who will help you determine the cause of the suspicious items. In the unlikely event that you fall victim to identity theft as a consequence of this incident, you will be assigned an ID Care Specialist who will work on your behalf to identify, stop and reverse the damage quickly.

You should also know that you have the right to file a police report if you ever experience identity fraud. Please note that in order to file a crime report or incident report with law enforcement for identity theft, you will likely need to provide some kind of proof that you have been a victim. A police report is often required to dispute fraudulent items. You can report suspected incidents of identity theft to local law enforcement or to the Attorney General.

4. Place Fraud Alerts with the three credit bureaus. If you choose to place a fraud alert, we recommend you do this after activating your credit monitoring. You can place a fraud alert at one of the three major credit bureaus by phone and also via Experian's or Equifax's website. A fraud alert tells creditors to follow certain procedures, including contacting you, before they open any new accounts or change your existing accounts. For that reason, placing a fraud alert can protect you, but also may delay you when you seek to obtain credit. The contact information for all three bureaus is as follows:

Credit Bureaus

Equifax Fraud Reporting	Experian Fraud Reporting	TransUnion Fraud Reporting
1-866-349-5191	1-888-397-3742	1-800-680-7289
P.O. Box 105069	P.O. Box 9554	P.O. Box 2000
Atlanta, GA 30348-5069	Allen, TX 75013	Chester, PA 19022-2000
www.equifax.com	www.experian.com	www.transunion.com

It is necessary to contact only ONE of these bureaus and use only ONE of these methods. As soon as one of the three bureaus confirms your fraud alert, the others are notified to place alerts on their records as well. You will receive confirmation letters in the mail and will then be able to order all three credit reports, free of charge, for your review. An initial fraud alert will last for one year.

Please Note: No one is allowed to place a fraud alert on your credit report except you.

5. Security Freeze. By placing a security freeze, someone who fraudulently acquires your personal identifying information will not be able to use that information to open new accounts or borrow money in your name. You will need to contact the three national credit reporting bureaus listed above to place the freeze. Keep in mind that when you place the freeze, you will not be able to borrow money, obtain instant credit, or get a new credit card until you temporarily lift or permanently remove the freeze. There is no cost to freeze or unfreeze your credit files.

6. You can obtain additional information about the steps you can take to avoid identity theft from the following agencies. The Federal Trade Commission also encourages those who discover that their information has been misused to file a complaint with them.

California Residents: Visit the California Office of Privacy Protection (www.oag.ca.gov/privacy) for additional information on protection against identity theft. Office of the Attorney General of California, 1300 I Street, Sacramento, CA 95814, Telephone: 1-800-952-5225.

Kentucky Residents: Office of the Attorney General of Kentucky, 700 Capitol Avenue, Suite 118 Frankfort, Kentucky 40601**,** www.ag.ky.gov, Telephone: 1-502-696-5300.

Maryland Residents: Office of the Attorney General of Maryland**,** Consumer Protection Division 200 St. Paul Place Baltimore, MD 21202**,** www.oag.state.md.us/Consumer, Telephone: 1-888-743-0023.

New Mexico Residents: You have rights pursuant to the Fair Credit Reporting Act, such as the right to be told if information in your credit file has been used against you, the right to know what is in your credit file, the right to ask for your credit score, and the right to dispute incomplete or inaccurate information. Further, pursuant to the Fair Credit Reporting Act, the consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information; consumer reporting agencies may not report outdated negative information; access to your file is limited; you must give your consent for credit reports to be provided to employers; you may limit "prescreened" offers of credit and insurance you get based on information in your credit report; and you may seek damages from a violator. You may have additional rights under the Fair Credit Reporting Act not summarized here. Identity theft victims and active duty military personnel have specific additional rights pursuant to the Fair Credit Reporting Act. You can review your rights pursuant to the Fair Credit Reporting Act by visiting www.consumerfinance.gov/f/201504_cfpb_summary_your-rights-under-fcra.pdf, or by writing Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

New York Residents: the Attorney General may be contacted at: Office of the Attorney General, The Capitol, Albany, NY 12224-0341; 1-800-771-7755; https://ag.ny.gov/.

North Carolina Residents: Office of the Attorney General of North Carolina**,** 9001 Mail Service Center Raleigh, NC 27699-9001, www.ncdoj.gov, Telephone: 1-919-716-6400.

Oregon Residents: Oregon Department of Justice, 1162 Court Street NE, Salem, OR 97301-4096, www.doj.state.or.us/, Telephone: 1-877-877-9392

Rhode Island Residents: Office of the Attorney General, 150 South Main Street, Providence, Rhode Island 02903, www.riag.ri.gov, Telephone: 1-401-274-4400

All US Residents: Identity Theft Clearinghouse, Federal Trade Commission, 600 Pennsylvania Avenue, NW Washington, DC 20580, https://consumer.ftc.gov, 1-877-IDTHEFT (438-4338), TTY: 1-866-653-4261.

Sample Media Notification Statement/Release – Document to be Reviewed and Customized Prior to Use.

[Insert Date]

Contact: [Insert Contact Information Including Phone Number/E-Mail Address]

IMMEDIATE RELEASE

[INSERT NAME OF ORGANIZATION] NOTIFIES PATIENTS OF BREACH OF UNSECURED PERSONAL INFORMATION

[Insert Name of Organization] notified [Insert Number] patients of a breach of unsecured personal patient protected health information after discovering the following event:

Describe event and include the following information as communicated to the victims:

A. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
B. A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved).
C. Any steps the individual should take to protect themselves from potential harm resulting from the breach.
D. A brief description of what the organization is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches.
E. Contact procedures for individuals to ask questions or learn additional information, which includes a toll-free telephone number, an e-mail address, Web site, or postal address.

In conjunction with local law enforcement and security experts, [Name of Organization] is working to notify impacted patients to mitigate the damages of the breach. [Name of Organization] has in place safeguards to ensure the privacy and security of all patient health information. As a result of this breach, steps are underway to further improve the security of its operations and eliminate future risk.

In a notification to patients, [Name of Organization] has offered their resources as well as …. [Insert as Applicable]. [Name of Organization] also has encouraged its

patients to contact their financial institutions to prevent unauthorized access to personal accounts.

[Name of Organization] has trained staff available for patients to call with any questions related to the data breach. Patients may call [Insert Phone Number Here] from [Insert Hours] with any questions. In addition, patients may visit [Name of Organization's] Web site at [Insert Web Address] for further information.

[Name of Organization] understands the importance of safeguarding our patients' personal information and takes that responsibility very seriously," said [Insert Name], President and CEO. "We will do all we can to work with our patients whose personal information may have been compromised and help them work through the process. We regret that this incident has occurred, and we are committed to prevent future such occurrences. We appreciate our patients support during this time.

Please direct all questions to [Enter Contact Information].

Notice to the Secretary of HHS of Breach of Unsecured Protected Health Information

Breach Affecting

○ 500 or More Individuals ○ Less Than 500 Individuals

Report Type

○ Initial Breach Report ○ Addendum to Previous Report

Section 1 - Covered Entity

Name of Covered Entity: John Doe

Address: Line 1

Line 2

City: City

State: AL Zipcode: XXXXX

Contact Name: John Doe

Contact Phone Number: XXX-XXX-XXXX

Contact E-mail: example@example.com

Type of Covered Entity: Health Plan

Section 2 - Business Associate
Complete this section if breach occurred at or by a Business Associate

Name of Business Associate: John Doe

Address: Line 1

Line 2

City: City

Business Associate Contact Name: John Doe

Business Associate Contact Phone Number: XXX-XXX-XXXX

Business Associate Contact E-mail: example@example.com

State: AL Zipcode: XXXXX

Section 3 - Breach

Date(s) of Breach: MM/DD/YYYY (- MM/DD/YYYY) mm/dd/yyyy - mm/dd/yyyy

Date(s) of Discovery: MM/DD/YYYY (- MM/DD/YYYY) mm/dd/yyyy - mm/dd/yyyy

Approximate Number of Individuals Affected by the Breach:

Type of Breach: Please select the type of breach. If type breach is "Other", please describe the type of breach in the field below.

- ☐ Theft
- ☐ Loss
- ☐ Improper Disposal
- ☐ Unauthorized Access/Disclosure
- ☐ Hacking/IT Incident
- ☐ Unknown
- ☐ Other

Type of Breach (Other):

Location of Breached Information: Please select the location of the information at the time of the breach. If breach type is "Other", please describe the location of the information in more detail in the Description section below.

- Laptop
- Desktop Computer
- Network Server
- E-mail
- Other Portable Electronic Device
- Other

Type of Protected Health Information Involved in the Breach:

- Demographic Information
- Financial Information
- Clinical Information
- Other

Brief Description of the Breach:

Please include the location of the breach, a description of how the breach occurred, and any additional information regarding the type of breach, type of media, and type of protected health information involved in the breach.

Safeguards in Place Prior to Breach: Please indicate what protective measures were in place prior to the breach

- Firewalls
- Packet Filtering (router-based)
- Secure Browser Sessions
- Strong Authentication
- Encrypted Wireless
- Physical Security

Section 4 - Notice of Breach and Actions Taken

Date(s) Individual Notice Provided: MM/DD/YYYY (- MM/DD/YYYY)

mm/dd/yyyy - mm/dd/yyyy

Was Substitute Notice Required? ○ Yes ◉ No

Was Media Notice Required? ○ Yes ◉ No

Actions Taken in Response to Breach: Please select the actions taken to respond to the breach. If selecting the "Other" category, please describe the actions taken in the section below.

- Security and/or Privacy Safeguards
- Mitigation
- Sanctions
- Policies and Procedures
- Other

Describe Other Actions Taken: Please describe in detail any actions taken following the breach in addition to those selected above.

Section 5 - Attestation

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: Full Name Date: mm/dd/yyyy
Typing your name represents your signature
MM/DD/YYYY

Submit