

DDS Information Security Incident Response Reporting Form

DS5340 (Revised May 2020)

Covered Entity:

Name of Covered Entity: _____
 Type of Covered Entity: _____

Business Associate: (Completion of this section is required if the breach occurred at or by a Business Associate)

Name of Business Associate: _____
 Street address: _____
 City: _____
 State: _____
 Zip: _____

Business Associate point of contact:

First Name: _____
 Last Name: _____
 Email address: _____
 Work phone (including area code): _____

Number of individuals affected: _____**Breach Dates:** Unknown

Breach Start Date: _____
 Breach End Date: _____

Discovery Dates:

Discovery Start Date: _____
 Discovery End Date: _____

Type of Breach:

- Hacking/IT incident
 Improper disposal
 Loss
 Theft
 Unauthorized access/disclosure

Location of Breach:

- Desktop computer
 Electronic medical record
 Email
 Laptop
 Network server
 Other portable electronic device
 Paper/films
 Other _____

Type of personal information involved:

- Personal Health Information (PHI)**
 Clinical
 Demographic
 Financial
 Other _____

Demographic:

- Name
 Address/ZIP
 Date of Birth
 Driver License number
 SSN
 UCI / other unique identifier

Clinical Diagnosis/Conditions:

- Lab Results
 Medications
 Other Treatment Information

Other identifiable information - Financial

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

Brief description of the breach:

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Safeguards in place prior to the incident:

- None
- Privacy Rule Safeguards (training, policies and procedures, etc.)
- Breach: Security Rule Administrative Safeguards (risk analysis, risk monitor, etc.)
- Security Rule Physical Safeguards (access controls, workstation security, etc.)
- Security Rule Technical Safeguards (access controls, transmission security, etc.)

Individual Notice Provided

Individual notice provided start date: _____

Individual notice provided end date: _____

Who Notified:

Name of individual that provided notification of the breach: _____ Is there out of date contact information for 10 or more individuals affected, requiring substitute notice? _____. If so, was substitute notice provided? _____

If the breach affected more than 500 individuals, was media notice provided? _____. If so, what date was the media notice provided?

If breach affected more than 500 individuals, was the California Attorney General's office notified? _____. If so, what date was notice provided? _____

If business associate is a healthcare provider licensed by CA Dept. of Public Health (CDPH), did it notify CDPH? _____. If so, what date was notice provided? _____

Was notice provided to OCR? _____. If so, what date was notice provided? _____

Description of the Corrective actions:

- Adopted encryption technologies
- Changed password/strengthened password requirements
- Created a new/updated Security Rule Risk Management Plan
- Implemented new technical safeguards
- Implemented periodic technical and nontechnical evaluations
- Improved physical security
- Performed a new/updated Security Rule Risk Analysis
- Provided business associate with additional training on HIPAA requirements
- Provided individuals with free credit monitoring
- Revised business associate contracts
- Revised policies and procedures
- Sanctioned workforce members involved (including termination)
- Took steps to mitigate harm
- Trained or retrained workforce members
- Other: _____

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Signatures:

Printed Name of Information Security Officer	Signature of Information Security Officer	(Date)
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Printed Name of Privacy Officer <i>(Required if privacy incident occurred whether or not notices were sent)</i>	Signature of Privacy Officer	(Date)
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Email this completed report to ISO@dds.ca.gov

Review Schedule and Revision History

Date	Description of Change	Reviewer
05/26/2020 V2r0	Revised to align with the HHS/OCR Federal and State reporting structure. Changed the order and type of data collected to meet minimum Federal and State reporting requirements.	ISO