



## Community Health Network of Washington Privacy/Security Incident Report

Use this form to report to Community Health Network of Washington (CHNW) a potential privacy or security incident and provide as much detail as possible. If protected health information (PHI) was sent to the incorrect recipient, ask for assurance that the PHI was not kept or used. Send your completed form to one of the following:

- Email at: [compliance.incident@chpw.org](mailto:compliance.incident@chpw.org).
- Fax at: (206) 521-8834
- Mail to:  
Community Health Network of Washington  
Attn: VP, Compliance Officer  
1111 3<sup>rd</sup> Ave, Ste. 400  
Seattle, WA 98101

### 1. Person Completing the Report

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Name (if applicable): \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

### 2. Incident Details

Notification by:  Member Call  Provider Call  Self-Report

Other: \_\_\_\_\_

Date of Report: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Number of Members Affected: \_\_\_\_\_

Type of Material (EOB, ID Card, Roster, etc.): \_\_\_\_\_

Location:  Paper/Mail  Email  Fax

Electronic Medical Record  Lost Computer/PDA



Media (CD, USB flash drive, etc.)  Other: \_\_\_\_\_

**3. Affected Member Details**

**Member Name:** \_\_\_\_\_ **Member ID:** \_\_\_\_\_

**Member Date of Birth:** \_\_\_\_\_ **Member Line of Business:** \_\_\_\_\_

**Member Phone:** \_\_\_\_\_ **Member Email:** \_\_\_\_\_

**Member Address:** \_\_\_\_\_

**4. PHI Received By/Disclosed To**

**Name of Individual or Organization:** \_\_\_\_\_

**Member ID or Provider NPI/TIN:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Intended Fax Number:** \_\_\_\_\_ **Actual Fax Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**5. Description of Incident** (describe what happened. Include details, names, and dates)

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**6. Corrective Actions** (has anything been done to address the issue so far?)

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