



Form SF-1090



OPERATOR LOG AUDIT INCIDENT REPORT FORM

INCIDENT DATE: _____ REPORT DATE: _____

OPERATOR (STAFF) NAME: _____ PHYSICIAN NAME: _____

ATTACH COPY OF THE AUDIT LOG WITH PATIENT NAMES, DATES AND TIMES AND COMMENTS

STAFF NAME COMPLETING REPORT: _____

STAFF NAME(S) INVOLVED IN INCIDENT: _____

NATURE OF INCIDENT: [] Viewed unauthorized patient data [] Altered unauthorized data [] Copied/Downloaded unauthorized data [] Other, please explain any of these incidents in detail below.

CONSEQUENCE OF THE ERROR: (i.e. patient information altered needs correction, stolen, sold, etc.)

CORRECTIVE ACTION / SANCTION PLAN: (Work with HIPAA Privacy Officer to develop plan to prevent recurrence)

CORRECTIVE ACTION TIMEFRAME: [] Immediately [] One Week [] Two Weeks [] One Month

DATE FOR COMPLETION: _____ DATE COMPLETED: _____

A COPY OF THIS REPORT SHOULD BE SENT TO: the PHYSICIAN, the REGIONAL MANAGER, the PRIVACY OFFICER, and the SYSTEMS MANAGEMENT SECURITY OFFICER

