



Protecting Personal Health Information Policy Manual

Counseling Clinic
Psychology Department

Reporting a Confidentiality or Data Breach

POLICY: Any and all confidentiality breaches must be reported to the Clinic Director including those who observe a possible breach and are not directly responsible for the breach. Student Counselors are encouraged to support each other with confidentiality compliance by keeping each other in check when non-compliance is observed. The majority of incidents are accidental or inadvertent, however, it is still essential to report them so that the Clinic can identify incident trends and internal control weakness that can be improved upon.

Student counselors are also expected to report internal control weaknesses that may lead to a breach and are encouraged to contribute solutions that can be implemented in the program.

When a disclosure of PHI occurs that violates the Privacy Rule, it is to be initially assumed that a breach occurred until the entity demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment conducted by the HIPAA Officer.

A breach is defined under HIPAA as the acquisition, access, use or disclosure of protected health information in a manner not permitted by the Privacy rule, which compromises the security or privacy of the protected health information.

A breach does not include:

- Any unintentional acquisition, access, or use of protected health information by a workforce member (i.e. Counseling Clinic faculty or staff), or a person acting under the authority of a covered entity or a business associate (i.e. student counselor or volunteer), 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 under the Privacy rule.
- Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information 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 under the Privacy rule.
- A disclosure of protected health information 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.

REPORTING PROCEDURE:

1. Student counselors are to report any and all confidentiality breaches to their supervisors.
2. Supervisors are to direct the student counselor to complete an on-line breach report form and notify the Clinic Director.

Breach Report Form:

https://www.az1.qualtrics.com/jfe/preview/SV_9mhLauhUWCEu3pr

3. Once completed, the breach report form is sent automatically to the University HIPAA Officer.
4. The HIPAA Officer will conduct a breach risk assessment and email the completed incident report to the Clinic Director to confirm the student followed through with the reporting requirement.
5. The Clinic Director will also conduct a breach risk assessment and consult with the Department Chair and HIPAA Officer if deemed necessary. The HIPAA Officer may initiate contact with the Clinic Director based on the results of the risk assessment.
6. Depending on the scope and nature of the breach, consequences for the student counselor may be considered by the Clinic Director who may consult with the student's supervisor, the Department Chair, the University HIPAA Officer, and/or the Dean of Students Office. Determinations are based on the breach risk assessment and factors surrounding the student and the breach incident.