Privacy Incident Report

Name:_____ **DOB** __ /___/____ **Date** _____
Optional

Home address: _____
Optional

Home telephone: _____
Optional

Clinic location where the incident occurred: _____

Internal:

Position: _____ Supervisor: _____

1. Description of possible violation

_____

_____

_____

_____

_____

_____

_____

_____

2. When did this occur?

_____

_____

3. Person(s) involved:

_____

_____

_____

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4. How did you come to learn of the incident described above?

_____

_____

_____

5. Would you be willing to discuss the above allegations with a member of the compliance committee, management or our attorney for the Practice?

_____

6. Have you discussed the above allegations with anyone else? If so, who?

_____

7. Are you aware of any other individuals who may be able to provide further information regarding the above allegations?

_____

Note: We will take every measure to ensure the confidentiality of the above information. However, there may be unforeseen circumstances where disclosure of this information may become necessary.

Signature_____ Date _____
Optional

Please submit to:

Medical Associates of Northwest Arkansas (MANA) Privacy Officer:
Taylor Hallwachs
HIPAA/Compliance Director
3383 N. MANA Court, Suite 201
Fayetteville, AR 72703
Phone: 479-571-6780 Fax: 479-443-4871
Taylor.Hallwachs@mana.md