AUGUSTA UNIVERSITY

DISCLOSURE DECLARATION-BREACH MITIGATION

Augusta University and AU Health System (AU Medical Center and AU Medical Associates) is required by law to attempt to retrieve records released without authorization, we are asking that you assist in mitigating the incident by submitting the following statement. Please complete this form and return it with any records/documentation you received. Thank you.

DECLARATION

My name is _____. I am at least 18 years of age and I received confidential information that was not intended for me.

☐ I am returning all copies in a self-addressed envelope provided to me or in an envelope addressed to:

Augusta University
Compliance, Ethics, and Risk Management - Room HS-3526
1120 15th Street
Augusta, GA 30912

☐ The information was deleted and/or purged by IT from my augusta.edu email account.

☐ The information was deleted and/or purged by IT from my business account (not AU) email account.

☐ The information was deleted and/or purged from my personal email account.

☐ The information was shredded and I no longer have access.

☐ The medication I received for another patient has been returned to the pharmacy and I did not retain any of the information about the other patient

☐ Other (Please explain):

With my signature, I declare that I have not made, retained, nor used or shared in any way, a copy of the documentation or information disclosed to me.

Signature: _____ Date: _____

Print Name: _____ Company /Dept (if applicable): _____

If you've shared the information with others, please list the names and contact information of those individuals below: