



Confirmation of Destruction of Misdirected Correspondence Form

By completing this form, you are acknowledging that you have received and/ or viewed correspondence; or accessed data from eMedNY that was not intended for you or with whom you have no current affiliation. ***This also includes correspondence received in any electronic format by email and or transmission.*** If you have questions, please contact Lisa J. McKeen/ HIPAA Privacy and Security Administrator @ eMedNY (518) 257-4619.

Section A: Please complete indicated information below (Required)

- I am notifying eMedNY that I received correspondence electronically for which was not intended for myself or the affiliation for which I am a representative of;

Name of person completing this form

Date of Notification: _____

Section B: Check all that apply and complete the indicated information (Required)

- I am verifying that the electronic information for which I received in error; was
 - Deleted from any and all electronic devices (computer, laptop, any electronic device).
 - Not saved in any format; or in any location; or forwarded to anyone.
 - Type of correspondence received: _____

Please describe how you determined the correspondence was misdirected and briefly the contents of the electronic information:

Please read the instructions below in red; before proceeding to destruction process.....

******* Prior to destruction, the misdirected correspondence form should be faxed to Attn: Lisa J. McKeen (518) 257-4789. Commence destroying the documents only after a confirmed receipt is received on your fax machine. Use an approved technology; such as deleting the complete file to destroy the correspondence. By signing this you are verifying that there were no copies of this information retained, stored or forwarded to any person.**

- I am faxing this form as verification of destruction of the misdirected correspondence

Signature of Person Acknowledging Destruction

Name of Organization/ Business for which you are a representative of: _____

Signature of Witness of Destruction: _____

Your Fax Number: _____

Date & Time of signature: _____

The section below is to be completed by an eMedNY staff member:

Section C: Confirmation Statement (Required)

I, _____, _____ at _____
Print Name Print Title Phone Number

Confirm that I have received the proper verification/ notification from the listed entity of misdirected communication via fax; that there were no copies or information retained or forwarded to any unauthorized persons.

Signature of Provider/Authorized Representative

Date

email the completed form with all pertinent information requested on the form to:

eMedNY
email box: EMedNY_HIPAA_Privacy_and_Security@gdit.com
cc: To: Lisa.McKeen@GDIT.com
AJ.Gagnon@GDIT.com