**ALL FIELDS REQUIRED FOR COMPLIANCE**

# 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;**

_____ **Date of Notification:** _____

***Name of person completing this form***

***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 presentative 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

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