Break the Glass Audit Attestation

Facility Name:
Name:
Title:
Date:

☐ By checking this box, I agree that I have reviewed the Break the Glass report for to and verify that the information is accurate. If a user has improperly used the Break the Glass function, that user has been notified and retrained.

☐ By checking this box, I agree that I have reviewed the Break the Glass report for to and have found a breach in the system. Below is my report regarding the breach:

Please type your breach report here.

By signing below, I verify that the information I have provided is true.

	Date:

Please return this completed form within one week of the audit report date to HealtheConnections Support at support@healtheconnections.org .

HealtheConnections Use Only

HealtheConnections Policy Officer	Date: