CONFIDENTIAL

PRIVACY/HIPAA COMPLAINT FORM

For complaints of violation of your privacy rights, including your rights under the Privacy Regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You may submit your complaint to the CDPH Privacy Office or to the U.S. Department of Health and Human Services (DHHS) (for complaints of violation of HIPAA only), or to both agencies at the addresses provided below.

IMPORTANT NOTE: A HIPAA complaint to the DHHS must be filed with DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Regional Manager at the DHHS for good cause shown. CDPH may not refer your complaint to DHHS and has no responsibility to do so or authority to waive the 180-day time limit.

Mail this completed complaint form to:	You may file a complaint with the Regional Manager or DHHS at:
PRIVACY OFFICER **CA DEPARTMENT OF PUBLIC HEALTH** **PRIVACY OFFICE** **1415 L STREET, SUITE 500** **SACRAMENTO, CA 95814**	**REGIONAL MANAGER** **DEPARTMENT OF HEALTH AND HUMAN SERVICES** **OFFICE FOR CIVIL RIGHTS** **90 7TH STREET, SUITE 4-100** **SAN FRANCISCO, CA 94103**

INDIVIDUAL FILING COMPLAINT

Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:

Daytime Telephone Number (Required):	Evening Telephone Number:	E-Mail Address:	Best Hours to Reach You:

CONSENT TO DISCLOSE YOUR NAME

Please select one of the following:

☐ I consent to my name being disclosed to investigate this complaint.
☐ I do not consent to my name being disclosed. Please note that not using your name may limit or delay our ability to investigate this complaint.

INFORMATION ABOUT YOUR COMPLAINT

Name of organization your complaint is against:	Name of person your complaint is against:	Date(s) Action(s) Occurred:

Details of the complaint:
I have reason to believe that one or more of the following has occurred:

☐ The organization/person has inappropriately disclosed my health information or other confidential personal information.
☐ The organization has inappropriately used my protected health information.
☐ The organization/person has inappropriately disposed of my health information or other confidential personal information without protecting my privacy.
☐ The organization/person has denied me or my personal representative access to my health information or other confidential personal information.
☐ The organization/person has denied my request to amend my health information.
☐ The organization/person has denied another privacy right.
☐ The organization's privacy policies and procedures violate the law.

Please provide a detailed description of your complaint covering *what, when, who, how, where,* and *why.* You may attach additional pages if there is not enough space here:

Do you have witness(es)? ☐ YES ☐ NO
If YES, please provide the names, addresses, and telephone numbers of your witness(es) below:

Witness Name:	Address:	Telephone Number:
Witness Name:	Address:	Telephone Number:
Witness Name:	Address:	Telephone Number:

RESOLUTION OF YOUR COMPLAINT

Please describe how you believe that your privacy complaint could be resolved:

The Department may decide that your complaint does not violate the HIPAA privacy rule, or other applicable privacy laws or policies, but another organization may be able to help you. Please choose one of the following:

☐ I agree to have this complaint disclosed to another organization.
☐ I do not agree to have this complaint disclosed to another organization.

YOUR SIGNATURE

I certify that the information on this form is true and correct to the best of my information, knowledge, and belief.

(Signature) _____ Date: _____

PRIVACY STATEMENT (CA CIVIL CODE SECTION 1798.17)

THE INFORMATION COLLECTED ON THIS FORM IS USED TO INVESTIGATE AND RESOLVE YOUR PRIVACY COMPLAINT. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND ON FILE AT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, PRIVACY OFFICE. ALL INFORMATION REQUESTED ON THE FORM IS VOLUNTARY. NOT SUPPLYING THE VOLUNTARY INFORMATION REQUESTED MAY CAUSE A POSSIBLE DELAY IN THE INVESTIGATION AND/OR RESOLUTION OF YOUR COMPLAINT. ANY INFORMATION PROVIDED MAY BE DISCLOSED TO THE CALIFORNIA STATE AUDITOR, THE CALIFORNIA OFFICE OF HIPAA IMPLEMENTATION, THE CALIFORNIA OFFICE OF INFORMATION SECURITY, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OR TO OTHER STATE AND FEDERAL AGENCIES AS REQUIRED BY LAW.

YOU HAVE THE RIGHT TO REVIEW THE RECORDS WE KEEP ABOUT YOU DURING NORMAL BUSINESS HOURS. THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH PRIVACY OFFICER WILL, UPON REQUEST, INFORM YOU REGARDING THE LOCATION OF YOUR RECORDS AND THE CATEGORIES OF ANY PERSONS WHO USE THE INFORMATION IN THOSE RECORDS. FOR MORE INFORMATION, CONTACT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, PRIVACY OFFICE LISTED ON THE FRONT OF THIS FORM.

IMPORTANT NOTE: IT IS MANDATORY THAT A HIPAA COMPLAINT TO THE DHHS MUST NAME THE ENTITY THAT IS THE SUBJECT OF THE COMPLAINT AND DESCRIBE THE ACTS OR OMISSIONS BELIEVED TO BE IN VIOLATION OF THE APPLICABLE HIPAA REQUIREMENTS.
(45 C.F.R. § 160.306(b)(2))