HEALTH AND MEDICAL INFORMATION
HIPAA PRIVACY
COMPLAINT FILING FORM

If you have questions about this form, please contact the Privacy Officer at 209-525-5718. Anyone may file a complaint. Members of the workforce may use this form to report violations of HIPAA by others in the workforce.

1. YOUR INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
E-MAIL ADDRESS (IF AVAILABLE):	DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:
BEST WAY TO REACH YOU:	BEST HOURS TO REACH YOU:	

IF WE CANNOT REACH YOU, IS THERE SOMEONE ELSE WE CAN CONTACT? ☐ YES ☐ NO
NAME:
PHONE NUMBER:

DO YOU NEED ANY SPECIAL ACCOMODATIONS FOR US TO COMMUNICATE WITH YOU ABOUT THIS COMPLAINT? ☐ YES ☐ NO

2. INFORMATION ABOUT YOUR COMPLAINT

NAME OF THE ORGANIZATION, PROVIDER OR HEALTH PLAN YOUR COMPLAINT IS AGAINST:	NAME OF PERSON YOUR COMPLAINT IS AGAINST:	DATE YOU FIRST NOTICED ACTION OR BELIEVE A VIOLATION OF HEALTH INFORMATION PRIVACY RIGHTS OCCURRED:	DATE (S) ACTION (S) OCCURRED:

ARE YOU FILING THIS COMPLAINT FOR SOMEONE ELSE? ☐ YES ☐ NO
IF YES, WHOSE HEALTH INFORMATION PRIVACY RIGHTS DO YOU BELIEVE WERE VIOLATED?

3. DETAILS ABOUT YOUR COMPLAINT

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

- ☐ The organization/person has inappropriately disclosed my personal health information.
- ☐ The organization/person has inappropriately used my personal health information.
- ☐ The organization/person has inappropriately disposed of my personal health information.
- ☐ The organization/person has denied access to my personal health information.
- ☐ The organization/person has denied my amendment to my personal health information.
- ☐ The organization's privacy policies and procedures violate HIPAA requirements.

Please provide a detailed description of your complaint covering what, when, who, how, where, and if you know, why about what happened. You may attach additional pages if there is not enough space on this form. Please be specific about the time and date of the incident, if applicable.

DO YOU HAVE A WITNESS? ☐ YES ☐ NO

If yes, please provide the name, address and telephone number of the witness below:

WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER:

4. RESOLUTION OF YOUR COMPLAINT

PLEASE DESCRIBE HOW YOUR PRIVACY COMPLAINT COULD BE RESOLVED:

5. CONSENT TO DISCLOSE YOUR NAME (*Optional*)

Please select one of the following:

☐ I consent to my name being disclosed to investigate this complaint. We will divulge information about you in our investigation within the limits of the law.

☐ I do not consent to my name being disclosed. Not using your name may hinder our ability to complete the investigation.

6. YOUR SIGNATURE

SIGNATURE:	DATE:

Filing a complaint with the County is voluntary. Without the information provided above, the Privacy Officer may be unable to proceed with your complaint. We collect this information under the authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. We will use this information to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form will be treated confidentially. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the department for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under the Privacy Rule. You are not required to use this form. You may also write a letter or submit a complaint electronically with the same information. Complaints must be filed within 180 days of when you knew the act occurred. Any alleged violation must have occurred on or after April 14, 2003, or on or after April 14, 2004 for the County self-insured vision and dental plans or on or after January 1, 2012 for the County self-insured employee benefits plans.

7. HEALTH INFORMATION PRIVACY COMPLAINT FORM SUBMITTAL CHOICES

PLEASE DIRECT YOUR COMPLAINT TO THE PRIVACY OFFICER AT THE APPROPRIATE DEPARTMENT BASED ON WHERE THE ALLEGED VIOLATION TOOK PLACE:

☐ Behavioral Health & Recovery Services—800 Scenic Drive, Modesto, CA 95350 (209) 525-6225

☐ Health Services Agency—Post Office Box 3271, Modesto, CA 95354 (209) 558-7034

☐ Risk Management—1010 Tenth Street, Suite 5900, Modesto, CA 95254 (209) 525-5718

Or you may file your complaint with the:

☐ County Privacy Officer at 1010 Tenth Street, Suite 5900 Modesto, CA 95354 (209) 525-5718

E-mail: CountyHIPAAPrivacyOfficer@stancounty.com

FOR OFFICE USE ONLY:	DATE COMPLAINT RECEIVED:	MEDICAL RECORD NUMBER:	COMPLAINT #:
	INVESTIGATION ASSIGNED TO:	DATE ASSIGNED:	DATE COMPLETED: