State of California
Health and Human Services Agency Department of Health Care Services

# PRIVACY COMPLAINT FORM

File Number: _____

Anyone may report suspected violation of HIPAA or a violation of DHCS' privacy policies and procedures by DHCS, DHCS staff, or a business associate of DHCS. DHCS will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual, including DHCS employees, or business associate for filing a complaint. The information you provide here will remain confidential to the extent possible. DHCS may need to share the information you provide to investigate your complaint. You may submit your complaint to either the Department of Health Care Services and/or to the U.S. Department of Health and Human Services.

| Mail this completed form to: | You may file a complaint with the secretary of DHHS at: |
|---|---|
| Privacy Officer<br>Department of Healthcare Services<br>C/O Office of Legal Services<br>P.O. Box 997413<br>MS 0010<br>Sacramento, CA 95899-7413 | Secretary of the Department of Health and Human Services<br>U.S. Office for Civil Rights<br>50 United Nations Plaza, Room 322<br>San Francisco, CA 94102 |

| **Individual Information** | | |
|---|---|---|
| Last Name: | First Name: | Middle Initial: |
| Address: | City/State: | Zip Code: |
| Benefits ID Number: | Date of Birth: | |
| Telephone Number: | E-mail Address: | |

**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.

**Note:** Not using your name may hinder our ability to complete the investigation.

| Information About Your Complaint | | |
|---|---|---|
| Name of the organization your complain is against: | Name of the person(s) 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 protected health information.

☐ The organization/person has inappropriately used my protected health information.

☐ The organization/person has inappropriately disposed of my protected health information without protecting my privacy.

☐ The organization/person has denied access to my protected health information.

☐ The organization/person has denied my request to amend my protected 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 a witness or witnesses?

☐ Yes ☐ No

If yes, please provide the names, addresses, and telephone numbers of your witnesses 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:

| MEDI-CAL STATUS |
|---|
| Are you a Medi-Cal beneficiary? ☐ Yes ☐ No<br>Are you enrolled in the Genetically Handicapped Persons Program (GHPP) or the California Children's Services (CCS) program? ☐ Yes ☐ No |

| CONSENT TO REFER YOUR COMPLAINT TO ANOTHER ORGANIZATION |
|---|
| DHCS may decide that your complaint does not violate HIPAA or DHCS' privacy policies and procedures. However, DHCS may determine that another organization may be able to help you.<br>If DHCS determines that another organization may be able to help you, please select one of the following:<br>☐ I agree to have this complaint sent to another organization.<br>☐ I do not agree to have this complaint sent to another organization. |

**I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.**

| Your Signature: | Date: |
|---|---|
| | |