Policy Memorandum
2003-18
Exhibit 4

HEALTH AND MEDICAL INFORMATION
HIPAA PRIVACY
COMPLAINT FILING FORM

DATE:	FILE NUMBER:

The information you provide here will remain confidential to the extent possible, however we may need to divulge the information to investigate your claim. Anyone may file a complaint. Members of the workforce may use this form to report violations of HIPAA by others in the workforce.

You may submit your complaint to:

Complaint Officer's Name
Address
Telephone Number
Email Address

1. YOUR INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

ADDRESS:	CITY/STATE:	ZIP CODE:

EMAIL ADDRESS:	DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:

BEST WAY TO REACH YOU:	BEST HOURS TO REACH YOU:

EMPLOYEES ONLY	**EMPLOYEES MAY FILE COMPLAINTS ANONYMOUSLY**	UNIT TITLE:	SUPERVISOR'S NAME:

2. 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 not divulge information about you in our investigation within the limits allowed in law.

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

3. INFORMATION ABOUT YOUR COMPLAINT

NAME OF THE ORGANIZATION YOUR COMPLAINT IS AGAINST:	NAME OF PERSON YOUR COMPLAINT IS AGAINST:	DATE YOU FIRST NOTICED ACTION:	DATE(S) ACTION(S) OCCURRED:

HEALTH AND MEDICAL INFORMATION PRIVACY COMPLAINT FILING (Continued)

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 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 here.

DO YOU HAVE WITNESS(ES): ☐ NO ☐ YES

If yes, please provide the names, addresses and telephone numbers of your witness(s) below:

WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER:
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER:

4. RESOLUTION OF YOUR COMPLAINT

PLEASE DESCRIBE HOW YOUR PRIVACY COMPLAINT COULD BE RESOLVED:

5. YOUR SIGNATURE

SIGNATURE:	DATE:

HEALTH AND MEDICAL INFORMATION PRIVACY
COMPLAINT FILING
(Continued)

FOR INTERNAL ORGANIZATION USE ONLY – ORGANIZATION TRACKING FORM

PRIMARY INVESTIGATOR'S NAME	**FILE NUMBER:**	**DATE:**

Members of Investigative Team

Type of Complaint if not HIPAA related:

Early Disposal of Complaint:

☐ **The complaint was not HIPAA related or did not meet one of the above categories.**

☐ **The complaint was against a function that is not HIPAA covered.**

☐ **The complaint was referred to on *(date).***

Investigation Strategy: ***(Who to talk to, what files to access, what system/processes to review.)***

Documents Gathered:

Documents Reviewed:

Witnesses/Workforce Members Interviewed:
Claim or Report of Harmful Effects to Individual: **[45 C.F.R. § 164.502(j)]**
Verification of Harmful Effects to Individual, If Any: **[45 C.F.R. § 164.502(j)]**
Actions taken to Mitigate Harmful Effects (If Necessary): **[45 C.F.R. § 164.502(j)]**
BRIEF SUMMARY OF FINDINGS:

PROPOSED RESOLUTION:

☐ REFERRAL TO:	DATE:
DATE OF APPROVAL OF RESOLUTION:	DATE RESOLVED:
DATE COMPLAINANT NOTIFIED OF RESOLUTION:	
ADDITIONAL COMMENTS:	
FOLLOW UP AUDIT: (If Necessary[1])	
Date of Follow Up:	

[1] If the complaint deals with retaliation and the findings are positive, follow up is likely necessary.