



**HEALTH INFORMATION
PRIVACY/SECURITY COMPLAINT**

Name	Date of Birth		
Street Address	City	State	Zip Code
Phone:	Mobile:		
Date of Request	E-Mail Address:		

Are you filing this complaint for someone? Yes No
 If yes, whose health information privacy rights do you believe were violated?

NAME OF INDIVIDUAL _____

Who do you believe violated your (or someone else's) health information privacy right or committed another violation of the Privacy/Security Rule?

PERSON/ORGANIZATION			
STREET ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
When do you believe that the violation of health information rights occurred? LIST DATE(S)			

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy/security rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed)

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE:

DATE