

# County of Los Angeles Department of Mental Health (DMH)

HIPAA Privacy Rule: 45 C.F.R. § 164.530 (d)

## HIPAA PRIVACY COMPLAINT FORM

*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.*

### SECTION I – Person Filing the Privacy Complaint

LAST NAME	FIRST NAME	M.I.	BIRTH DATE	HOME PHONE #
STREET ADDRESS	APT. #	CITY		STATE
BEST WAY TO REACH YOU			BEST HOURS	

### SECTION II - HIPAA Privacy Complaint Form – Consent to Disclose Your Name (optional)

<input type="checkbox"/>	I consent to my name being disclosed to investigate this complaint. (Information about you in our investigation will not be disclosed, within the limits allowed by law.)
<input type="checkbox"/>	I do not consent to my name being disclosed. (Not using your name may hinder our investigation.)

### SECTION III - Privacy Complaint Filed Against

PERSON/ORGANIZATION				PHONE #	
ADDRESS	SUITE #	CITY	STATE	ZIP CODE	

**I have reason to believe that the organization/person:**

<input type="checkbox"/>	Inappropriately disclosed my personal health information.	<input type="checkbox"/>	Inappropriately used my personal health information.
<input type="checkbox"/>	Inappropriately disposed of my personal health information.	<input type="checkbox"/>	Denied my amendment to personal health information.
<input type="checkbox"/>	Denied access to my personal health information.	<input type="checkbox"/>	The organization's privacy policies and procedures violate HIPAA requirements.

Do you have witness(es)  Yes  No

WITNESS NAME:	ADDRESS:	PHONE #
WITNESS NAME:	ADDRESS:	PHONE #

