HIPAA PRIVACY COMPLAINT FILING FORM

Middlesex Health System recognizes that an individual who believes that his or her privacy rights have been violated with respect to Protected Health Information has the right to complain without fear of retaliation. If you believe that your privacy rights or the privacy rights of another have been violated, you may file a complaint in writing with Middlesex Health System or with the Office of Civil Rights.

Middlesex Health System will not retaliate against you if you file a complaint.

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 Middlesex Health System workforce may use this form to report violations of HIPAA by others in the workforce.

You may submit your complaint to:

HIPAA Privacy Officer
Middlesex Health System
28 Crescent Street
Middletown, CT 06457
(860) 358-4630
HIPAA_Privacy_Office@midhosp.org

1. YOUR INFORMATION			
LAST NAME:	FIRST NAME:		MI:
ADDRESS:	CITY/STATE:		ZIP CODE:
EMAIL ADDRESS:	DAY TIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:	
BEST WAY TO REACH YOU:	BEST HOURS TO REACH YOU:		
EMPLOYEES ONLY	**EMPLOYEES MAY FILE COMPLAINTS ANONYMOUSLY**	DEPT NAME:	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:

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
- ☐ The organization/person has inappropriately accessed my personal health information
- ☐ The organization has violated HIPAA policies and procedures concerning another person's personal health information.

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:

If you prefer, you can make a complaint to: U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509 F, HHH Building, Washington D.C. 20201; https://www.hhs.gov/hipaa/filing-a-complaint/index.html; (800) 368-1019.