Form Approved: OMB No. 0990-0269
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

HEALTH INFORMATION PRIVACY COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME

HOME PHONE	WORK PHONE
( )	( )

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS *(If available)*

Are you filing this complaint for someone else? ☐ Yes ☐ No

If Yes, whose health information privacy rights do you believe were violated?

FIRST NAME	LAST NAME

Who (or what agency or organization, e.g., provider, health plan) do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

PERSON/AGENCY/ORGANIZATION

STREET ADDRESS	CITY

STATE	ZIP	PHONE
		( )

When do you believe that the violation of health information privacy rights occurred?

LIST DATE(S)

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy 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.

SIGNATURE	DATE

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under the Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at: **www.hhs.gov/ocr/privacyhowtofile.html**. To mail a complaint see reverse page for OCR Regional addresses.

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for OCR to communicate with you about this complaint? *(Check all that apply)*

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter *(specify language)*: _____

☐ Foreign language interpreter *(specify language)*: _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
HOME PHONE ( )	WORK PHONE ( )

STREET ADDRESS	CITY

STATE	ZIP	E-MAIL ADDRESS *(If available)*

Have you filed your complaint anywhere else? If so, please provide the following. *(Attach additional pages as needed)*

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) *(If known)*

To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).

ETHNICITY *(select one)*

☐ Hispanic or Latino

☐ Not Hispanic or Latino

RACE *(select one or more)*

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other *(specify)*: _____

PRIMARY LANGUAGE SPOKEN *(if other than English)*

How did you learn about the Office for Civil Rights?

☐ HHS Website / Internet Search ☐ Family / Friend / Associate ☐ Church / Community Org ☐ Lawyer / Legal Org ☐ Phone Directory ☐ Employer

☐ Fed / State / Local Gov ☐ Healthcare Provider / Health Plan ☐ Conference / OCR Brochure ☐ Other *(specify)*:

To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged discrimination took place.

Region I - CT, ME, MA, NH, RI, VT
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

Region II - NJ, NY, PR, VI
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3313
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

Region III - DE, DC, MD, PA, VA, WV
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

Region IV - AL, FL, GA, KY, MS, NC, SC, TN
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 3B70
Atlanta, GA 30323
(404) 562-7886; (404) 331-2867 (TDD)
(404) 562-7881 FAX

Region V – IL, IN, MN, OH, WI
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

Region VI – AR, LA, NM, OK, TX
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

Region VII – IA, KS, MO, NE
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

Region VIII - CO, MT, ND, SD, UT, WY
Office for Civil Rights, DHHS
1961 Stout Street - Room 1426
Denver, CO 80294
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

Region X - AK, ID, OR, WA
Office for Civil Rights, DHHS
2201 Sixth Avenue - Mail Stop RX-11
Seattle, WA 98121
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201.