DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE FOR CIVIL RIGHTS (OCR)



PATIENT SAFETY CONFIDENTIALITY COMPLAINT

| YOUR FIRST NAME | | YOUR LAST | YOUR LAST NAME | | |
|----------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--|
| HOME PHONE () | | WORK PHON | WORK PHONE | | |
| STREET ADDRESS | | | CITY | | |
| STATE | ZIP | E-MAIL ADDR | RESS (If available) | | |
| Who is the FIRST NAME or BUSINES: | | er who is identified in the informatio LAST NAME | the information you believe was impermissibly disclosed? LAST NAME | | |
| Who (e.g., provider, pa patient safety confider PERSON/AGENCY/ORGA | itiality? | , other person) do you believe dis | sclosed patient safety work prod | luct in viola | |
| STREET ADDRESS | | | CITY | | |
| STATE | ZIP | PHONE () | | | |
| When do you believe to LIST DATE(S) | hat the impermissible dis | sclosure occurred? | | | |
| Describe briefly what h product? Please be as additional pages as ne | specific as possible. WI | do you believe a person or organ ny do you believe the information | ization impermissibly disclosed disclosed is patient safety wor | patient saf k product? | |
| Please sign and date the SIGNATURE | nis complaint. | | DATE | | |
| Filing a complaint wit | h OOD in valendam. He | | I CONTRACTOR OF THE PROPERTY O | | |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to with your complaint. We collect this information under the Patient Safety and Quality Improvement Act of 2005 (Patier Act). We use it to investigate your complaint to see whether enforcement action is appropriate. The Privacy Act of 1974 the information submitted on this form. We may share your information with the Department of Justice or a court in the elawsuit, with another agency that has jurisdiction over potential violations or reviews certifications of Patier Organizations, or with others who help us carry out our work. Otherwise, OCR will not share your name or other information about you unless you agree. You are not required to use this form. You may write a letter or submit a electronically with the same information. You will find directions for submitting an electronic complaint on our we http://www.hhs.gov/OCR/Privacy/PSA/howtofile.html. To mail a complaint see reverse page for OCR address.



| 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 us to communicate with you about this complaint? (Check all that apply) Braille | | | | | |
| Sign language interpreter (specify language): | | | | | |
| Foreign language interpreter (specify | language): | Other: | | | |
| To help us better serve you, answer the following question: | | | | | |
| 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): | | | | | |
| 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 | | |
| | | 1 = | | | |
| STATE | ZIP | E-MAIL ADDRESS (If a | vallable) | | |
| | | | | | |
| 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) | | | |
| • | • | | <u> </u> | | |

To mail a complaint, please type or print, and return completed complaint to:

Office for Civil Rights
Department of Health and Human Services
Attn: Patient Safety Act
200 Independence Ave., SW, Rm. 509F
Washington, DC 20201
(202) 619-0403

TDD 1-800-537-7697 FAX: (202) 619-3818

To submit an electronic complaint, see our web site at http://www.hhs.gov/OCR/Privacy/PSA/howtofile.html .

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 20 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.





COMPLAINANT CONSENT FORM

The Department of Health and Human Services (HHS), Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects federal records about an individual containing personally identifiable information and allows OCR to use your name or other personal information only when necessary to complete the investigation of your complaint.

Additionally, OCR may be required to disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to other federal, foreign, state, or local public agencies.

If a request is made under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Although consent to reveal your identity or identifying information about you to the entity or agency under investigation or to other persons, agencies, or entities is not required in order to investigate your complaint, failure to give consent is likely to impede the investigation of your complaint and may result in closure of the investigation.

Please read and review the documents entitled, <u>Protecting Personal Information in Complaint Investigations</u> and <u>Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights</u> for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please keep one copy for your records.

• As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.





- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.
- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

| CONSENT: I have read and I underst to reveal my identity or identifying information agency under investigation or to other persons | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| CONSENT DENIED: I have read a permission to OCR to reveal my identity understand that this denial of consent is becomplaint and may result in closure of the investigation. | or identifying information about me. likely to impede the investigation of my |
| Signature: | Date: |
| Name: | |
| Address: | |
| Telenhone Number | |