DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

PATIENT SAFETY CONFIDENTIALITY COMPLAINT

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

STREET ADDRESS	CITY

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

Who is the patient, provider or reporter who is identified in the information you believe was impermissibly disclosed?

FIRST NAME or BUSINESS NAME	LAST NAME

Who (e.g., provider, patient safety organization, other person) do you believe disclosed patient safety work product in violat patient safety confidentiality?

PERSON/AGENCY/ORGANIZATION

STREET ADDRESS	CITY

STATE	ZIP	PHONE ( )

When do you believe that the impermissible disclosure occurred?

LIST DATE(S)

Describe briefly what happened. How and why do you believe a person or organization impermissibly disclosed patient safe product? Please be as specific as possible. Why do you believe the information disclosed is patient safety work product? *(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

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 (Patie 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 e lawsuit, with another agency that has jurisdiction over potential violations or reviews certifications of Patien Organizations, or with others who help us carry out our work. Otherwise, OCR will not share your name or other id information about you unless you agree. You are not required to use this form. You may write a letter or submit a c electronically with the same information. You will find directions for submitting an electronic complaint on our we http://hhs.gov/ocr/privacy/psa/complaint/index.html. To mail a complaint see reverse page for OCR address.

Form Approved: OMB No. 0935-0143
See OMB Statement on Reverse

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

☐ 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 ☐ Religious / Community Org ☐ Lawyer / Legal Org ☐ Phone Directory ☐

☐ 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
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 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://hhs.gov/ocr/privacy/psa/complaint/index.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 reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send c regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS 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 certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may 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 another appropriate agency.

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.

Please read and review the documents entitled, *Protecting Personal Information in Complaint Investigations* and *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* 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 make 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, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☐ **CONSENT DENIED**: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: _____ Date: _____

** You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please type or print): _____

Address: _____

Telephone Number: _____