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	ZIP CODE

BEST WAY TO REACH YOU	BEST HOURS

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

☐ 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.)

☐ 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:

☐ Inappropriately disclosed my personal health information;

☐ Inappropriately disposed of my personal health information;

☐ Denied access to my personal health information;

☐ Inappropriately used my personal health information;

☐ Denied my amendment to personal health information

☐ 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 #**

HIPAA PRIVACY COMPLAINT FORM (Continued)

Please provide a detailed description of your privacy complaint, covering what, when, how, where and, if you know, why it happened. To provide more information, attach additional pages.

Filing a complaint with DMH is voluntary. However, without the information requested above, DMH may be unable to proceed with the investigation of your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. 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 DMH for purposes associated with health information privacy compliance and as permitted by law. **DMH may not 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 may write a letter to submit a complaint with the same information. Mail the complaint to County of Los Angeles – Department of Mental Health, Patients' Rights Office, 550 South Vermont Avenue, Los Angeles, CA 90020. You may also file a complaint with the Office for Civil Rights, U.S. Department of Health & Human Services.

Signature of Client/Client's Representative/ Person Submitting Complaint

Date

If signed by client's personal representative, state relationship and authority to do so.

- **Did you complete the information requested on the form?**
- **Did you list your phone number and address where we can contact you?**
- **Please don't forget a postage stamp.**