



If you believe that this office or one of its business associates has violated HIPAA Privacy, Security or Breach Notification Rules or Policies, you may [file a complaint with us](#) or [the Secretary of the U.S. Department of Health and Human Services \(HHS\) Office for Civil Rights \(OCR\)](#).

Office of the County Counsel

Health Information Privacy and Security Complaint Form

YOUR FIRST NAME		YOUR LAST NAME	
HOME PHONE (Please include area code)		WORK PHONE (Please include area code)	
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/security rights do you believe were violated?

FIRST NAME	LAST NAME
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What person(s) or entities representing or conducting services on behalf of the Office the County Counsel do you believe violated the HIPAA Privacy/Security Rule? PERSON / AGENCY / ORGANIZATION

STREET ADDRESS		CITY
STATE	ZIP	PHONE (Please include area code)

When do you believe that the violation(s) occurred?

LIST DATE(S)

Briefly describe/state the violation (what happened). How and why do you believe the HIPAA Privacy/Security/Breach Notification rules were violated? Please be as specific as possible. (Attach 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 is voluntary. However, without the information requested above, we may not be able to proceed with your complaint. We will use the information to evaluate your complaint and determine how we will process your complaint. Information submitted on this form is treated confidential. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, internal systems operations, or routine uses. This can include disclosure of information outside the Department for purposes associated with health information privacy compliance and as required or permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint. You are not required to use this form. You may also write a letter or submit a complaint electronically with the same information to us.

Submit your complaint to:

Office of the County Counsel
Information Security and Privacy Officer
 500 West Temple Street, Room 602
 Los Angeles, CA 90012
 Email: HIPAA@COUNSEL.LACOUNTY.GOV
 Tel: (213) 974 - 3489

Alternatively, you can also file your complaint with HHS-OCR at:

HHS-OCR
 Region IX, Office for Civil Rights
 U.S. Department of Health & Human Services 90 7th
 Street, Suite 4-100
 San Francisco, CA 94103
 (415) 437 - 8311 (TTD) / (415) 437- 8329 (Fax)