# HIPAA Privacy Complaint Form

Last Name: _____ First Name: _____ MI: _____

Mailing Address (Street or PO Box) _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Home Office Cell
If we cannot reach you directly, is there someone else we can contact to help us reach you?

Name: _____ Daytime Phone: _____

Are you filing this complaint for someone else? Yes ☐ No ☐
If yes, whose health information privacy rights do you believe were violated?

Last Name: _____ First Name: _____

Name of the person and/or facility you believe violated your (or someone else's) health information privacy rights or committed another violation of the HIPAA Privacy Rule?

_____

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

Briefly describe what happened. How and why do you believe your (or someone else's) health information privacy rights were violated or the HIPAA Privacy Rule was violated? Please be as specific as possible. (Attach additional pages as needed).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

OKC·County Health Department
Attn: HIPAA Officer
2600 NE 63rd Street
Oklahoma City, OK 73111

Adopted from Oklahoma State Department of Health ODH 303H
Clinical Services Division July 2014