

Health Insurance Portability and Accountability Act (HIPAA) Privacy Complaint

Name (Last, First, MI)		Daytime Area Code and Telephone No. <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Cell	
Address (Street or PO Box, City, State, ZIP)			
If we cannot reach you directly, enter the name of someone who can help us reach you.		Provide Contact Person's Daytime Area Code and Telephone No.	
Are you filing this complaint for someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide the first and last name of the person whose health information privacy rights you believe were violated.	
Provide the 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 the violation of health information privacy rights occurred?			
Briefly describe what happened. Please explain how you believe your (or someone else's) health information privacy rights were violated. Please also explain how you think the HIPAA Privacy Rule was violated. Be as specific as possible. (Attach additional pages as needed.)			

Signature

Date

With a few exceptions, you have the right to request and be informed about the information that the Health and Human Services Commission (HHSC) releases. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at P.O. Box 85200, Austin, Texas 78758.