HEALTH AND MEDICAL INFORMATION
HIPAA PRIVACY

COMPLAINT FILING FORM

DATE:	FILE NUMBER (AGENCY USE)

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.

You may submit your complaint to:

MORC, Inc.
Attention: Ombudsman
16200 Nineteen-Mile Road P. O. Box 380710
Clinton Township, Michigan 48038
PHONE (586) 263-8700 FAX (586) 412-7889 TTY/TTD (586) 286-5036
E-mail at ombudsman@morcinc.org

1. YOUR INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

ADDRESS:	CITY/STATE:	ZIP CODE:

EMAIL ADDRESS:	DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:

BEST WAY TO REACH YOU:	BEST HOURS TO REACH YOU:

FILE AN ANONYMOUS COMPLAINT

Please note if you choose to file anonymously it may hinder our ability to investigate your complaint and we will not be able to provide you with follow up information.

2. CONSENT TO DISCLOSE YOUR NAME (*Optional*)

Please select one of the following:

☐ I consent to my name being disclosed to investigate this complaint. We will not divulge information about you in our investigation within the limits allowed in law.

☐ I do not consent to my name being disclosed. Not using your name may hinder our ability to complete the investigation.

3. INFORMATION ABOUT YOUR COMPLAINT

NAME OF THE ORGANIZATION YOUR COMPLAINT IS AGAINST:	NAME OF PERSON YOUR COMPLAINT IS AGAINST:	DATE YOU FIRST NOTICED ACTION:	DATE(S) ACTION(S) OCCURRED:

HEALTH AND MEDICAL INFORMATION PRIVACY COMPLAINT FILING (Continued)

DETAILS OF THE COMPLAINT:

I have reason to believe that one or more of the following has occurred:

- ☐ The organization/person has inappropriately disclosed my personal health information.
- ☐ The organization/person has inappropriately used my personal health information.
- ☐ The organization/person has inappropriately disposed of my personal health information.
- ☐ The organization/person has denied access to my personal health information.
- ☐ The organization/person has denied my amendment to my personal health information.
- ☐ The organization's privacy policies and procedures violate HIPAA requirements.

Please provide a detailed description of your complaint covering *what, when, who, how, where, and if you know, why* about what happened. You may attach additional pages if there is not enough space here.

DO YOU HAVE WITNESS(ES): ☐ NO ☐ YES

If yes, please provide the names, addresses and telephone numbers of your witness(s) below:

WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER:
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER:

4. RESOLUTION OF YOUR COMPLAINT

PLEASE DESCRIBE HOW YOUR PRIVACY COMPLAINT COULD BE RESOLVED:

5. YOUR SIGNATURE

SIGNATURE:	DATE: