## 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
15600 Nineteen-Mile Road P. O. Box 380710
Clinton Township, Michigan 48038
PHONE (586) 263-8700 FAX (586) 412-7889
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: |
|---|---|