



Department of Social Services
Health Insurance Portability and Accountability Act Complaint

INFORMATION REGARDING INDIVIDUAL THAT IS THE SUBJECT OF HEALTH INFORMATION

Individual's Name _____ Social Security Number _____
 Date of Birth _____ Other Identifier: _____
 Address _____ Phone Number _____

INFORMATION REGARDING INDIVIDUAL FILING THIS COMPLAINT IF DIFFERENT FROM ABOVE

Complainant's Name _____ Phone Number _____
 Address _____
 Complainant's involvement or personal relationship/authority with the individual: _____

EXPLANATION OF REASON FOR COMPLAINT

Is your complaint about a disagreement with a DSS or Divisional HIPAA Policy or Regulation? If so, please specify your disagreement and your suggested remedy. _____

If your complaint is regarding information you feel was improperly released by DSS, please answer the following questions to the best of your knowledge.

Employee Name _____ DSS Division for which employee works: _____

Address/Location of the Employee's Office: _____

What information was released: _____

On what date(s) was the information released: _____

Who or what agency was the information released to: _____

Why do you feel the information should not have been released? _____

If complaint is for reasons not stated above, please state basis for complaint and explain. _____

