**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: _____

EXPLANATI 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. _____

_____

_____

Submit this form to the DSS Privacy Officer, PO Box 1527, Jefferson City, MO 65102