County of Sacramento

HIPAA PRIVACY COMPLAINT FORM

The information you provide here will remain confidential to the extent possible; however, we may need to release 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. (See Page 2 for Instructions)

YOUR FIRST NAME		YOUR LAST NAME
STREET ADDRESS		CITY/STATE/ZIP CODE
EMAIL	DAYTIME PHONE NUMBER	EVENING PHONE NUMBER

Are you filing this complaint for someone else? ☐ **Yes** ☐ **No**
If "Yes", whose health information privacy rights do you believe were violated?

FIRST NAME	LAST NAME

Who do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

PERSON/AGENCY/ORGANIZATION	
STREET ADDRESS	CITY/STATE/ZIP CODE
PHONE NUMBER	

When do you believe that the violation of health information privacy rights occurred?

LIST DATE(S):

Describe briefly, what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the Privacy Rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed)

☐ **I acknowledge I have read the instructions on page 2.**

Please sign and date this complaint.

_____	_____	____/____/____
Signature	**Print First and Last Name**	**Signature Date**

RETURN FORM TO:
Office of Compliance, 799 G Street, Suite 217, Sacramento, California 95814
Phone: (916) 874-2999 Fax: (916) 854-9507 Email: HIPAAOffice@saccounty.net

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INSTRUCTIONS:

Any person who believes their privacy rights have been violated by a County of Sacramento HIPAA covered component may file a formal complaint with the County of Sacramento using HIPAA Form 3009. This form is available from your County provider and is on the internet: http://www.compliance.saccounty.net.

The complaint must be in writing; and

- Describe acts or omissions believed to be in violation;
- Must be filed within 180 days of when the complainant knew or should have known that the act had occurred.

The County must respond within 30 days after receipt of complaint.

The information you provide here will remain confidential to the extent possible; however, we may need to release the information to investigate your claim.

Your signature on the Privacy Complaint form indicates that you have read these instructions.

Anyone can file a health information privacy or security complaint with the federal Department of Health and Human Services/Office for Civil Rights (OCR). Your complaint must be filed in writing by mail, fax, e-mail, or via the OCR Complaint Portal (https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf).

For more information about filing a complaint with the OCR visit their website: http://www.hhs.gov/hipaa/filing-a-complaint/index.html

Region IX - San Francisco (American Samoa, Arizona, California, Guam, Hawaii, Nevada)
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697