HIPAA Privacy Complaint Filing Form

OMES recognizes that an individual who believes that his or her privacy rights have been violated with respect to protected health information has the right to complain without fear of retaliation. If you believe that your privacy rights or the privacy rights of another have been violated by OMES, you may file a complaint in writing with OMES or with the Office for Civil Rights.

You may submit your complaint to: OMES HIPAA Privacy Officer 2401 N. Lincoln Blvd., Ste. 300 Oklahoma City, OK 73105

Member ID:		
First name:	Last name:	
Address:	City:	ZIP code:
Phone number:		
Email address:		
Best way to reach you:		
Best hours to reach you:		
If we cannot reach you, is there someone els	e we may contact?	
☐ Yes ☐ No		
If you answered Yes , please enter the person	n's name and contact information:	
Do you need any special accommodations fo	or us to communicate with you about this o	complaint?
Do you need any special accommodations for Yes No If you answered Yes , please describe the acc	·	·
☐ Yes ☐ No	·	·
☐ Yes ☐ No If you answered Yes , please describe the acc	·	·
Yes No If you answered Yes , please describe the accommon to disclose your name Please indicate your consent below:	commodations needed:seed to investigate this complaint. (OMES v	
Yes No If you answered Yes, please describe the accommon sent to disclose your name Please indicate your consent below: I consent to my name being disclose about you in our investigation within	sed to investigate this complaint. (OMES von the limits allowed in law.)	vill not divulge information
☐ Yes ☐ No If you answered Yes, please describe the accomment to disclose your name Please indicate your consent below: ☐ I consent to my name being disclose about you in our investigation within ☐ I do not consent to my name being	sed to investigate this complaint. (OMES von the limits allowed in law.)	vill not divulge information

Are you filling	out this complaint for someone else?		
☐ Yes	□ No		
If you answered Yes , whose health information privacy rights do you believe were violated? Provide the person's first and last name.			
etails of the co	omplaint		
Please indicat	e your complaint below:		
☐ The c	organization/person has inappropriately disclosed my personal health information.		
	organization/person has inappropriately used my personal health information.		
	organization/person has inappropriately disposed of my personal health information.		
	organization/person has denied access to my personal health information.		
	organization/person has denied my amendment to my personal health information. organization's privacy policies and procedures violate HIPAA requirements.		
Please provid regarding wha	e a detailed description of your complaint covering what, when, who, how, where, and if you know, what happened.		
Do you have v	witnesses?		
☐ Yes	□ No		
If you answere your witnesse	ed Yes , please provide the names, addresses and telephone numbers (one individual per line) of s below:		
Have you filed	this complaint with another agency/someone else?		
☐ Yes	□ No		
If you answer	ed Yes , please indicate with whom you filed:		

solution of your complaint		
Please describe how your priva	cy complaint could be resolved:	
unable to proceed with your con pursuant to the Health Insuranc determine if we have jurisdictior form will be treated confidentiall	evoluntary. Without the information provided above, the privacy officer may be implaint. We collect this information under the authority of the Privacy Rule issued to Portability and Accountability Act of 1996. We will use this information to in and, if so, how we will process your complaint. Information submitted on this y. Any information provided may be disclosed to the U.S. Department of Health in state and federal agencies as required by law.	
complaint or for taking any other this form. You may also write a	o intimidate, threaten, coerce, discriminate or retaliate against you for filing this raction to enforce your rights under the Privacy Rule. You are not required to use letter or submit a complaint electronically with the same information. Complaints when you knew the act occurred.	
Signature:	Date:	