Oklahoma State Department of Health
HIPAA Privacy Complaint Form

Last Name _____ First Name _____ MI: _____

Mailing Address (Street or PO Box) _____ City _____

State _____ Zip: _____ Daytime Phone: _____ Home □ Office □ Cell □

If we cannot reach you directly, is there someone else we can contact to help us reach you? _____

_____ Daytime Phone: _____

Are you filing this complaint for someone else? Yes _____ No _____

If yes, whose health information privacy rights do you believe were violated? _____

Last Name: _____ First Name _____

Name of the person and/or facility you believe violated your (or someone else's) health information privacy rights or committed another violation of the HIPAA Privacy Rule?

_____

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

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

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Signature _____ Date: _____