KERN COUNTY MENTAL HEALTH DEPARTMENT

Attachment B
Section No.: 10.1.20

Privacy Complaint Form

Date:	Medical Record #:

The information you provide here will remain confidential to the extent possible, however we may need to divulge 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.

You may submit your complaint to:

CONFIDENTIAL
Privacy Officer
Kern County Mental Health
P.O. Box 1000, Bakersfield, CA 93302
(888) 875-5559

1. YOUR INFORMATION

Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Email Address:	Daytime Telephone Number:	Evening Telephone Number:
Best Way to Reach You:	Best Hours to Reach You:	

Employees Only:	*EMPLOYEES MAY FILE COMPLAINTS ANONYMOUSLY*	RU#/Team Name:	Supervisor's Name:

2. CONSENT TO DISCLOSE YOUR NAME (*Optional*)

Please select one of the following:

☐ I consent to my name being disclosed to investigate this complaint. KCMH will not divulge information about you in our investigation within the limits allowed in law.

☐ I do not consent to my name being disclosed. I realize that not being able to release my name may hinder the completion of the investigation.

3. INFORMATION ABOUT YOUR COMPLAINT

Name of the Organization Your Complaint Is Against:	Name of Person Your Complaint Is Against:
Date you first noticed problem:	Date(s) Problem(s) Occurred:

Details of the Complaint:

I have reason to believe that one or more of the following has occurred:

☐ The organization/person has inappropriately disclosed personal health information.

☐ The organization/person has inappropriately used personal health information.

☐ The organization/person has inappropriately disposed of personal health information.

☐ The organization/person has denied access to personal health information.

☐ The organization/person has denied an amendment to personal health information.

☐ The organization/person has denied a requested restriction to personal health information.

☐ The organization's privacy policies and procedures violate HIPAA requirements.

☐ Other: (be specific) _____

Please provide a detailed description of your complaint covering *what, when, who, how, where, and if you know, why* about what happened. You may attach additional pages if there is not enough space here.

Do you have witness(es)? ☐ NO ☐ YES

If yes, please provide the names, addresses and telephone numbers of your witness(s) below:

Are the witnesses aware of your complaint? ☐ YES ☐ NO

Are the witnesses willing to cooperate or participate? ☐ YES ☐ NO

Witness Name:	Address:	Telephone Number:
Witness Name:	Address:	Telephone Number:

4. RESOLUTION OF YOUR COMPLAINT

Please describe how your privacy complaint could be resolved:

5. YOUR SIGNATURE

Signature:	Date: