HIPAA COMPLAINT

State Form 51512 (R/10-08)
Indiana State Department of Health

CONFIDENTIAL INFORMATION
per 45 CFR 164.530 (d)

INSTRUCTIONS: Send Completed Form to:
Office of HIPAA Compliance
Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204

Your First Name	**Your Last Name**
Home Telephone Number ( )	**Work Telephone Number** ( )
Street Address ***(number and street)***	**City**
State / **ZIP Code**	**E-Mail Address** ***(if available)***

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

If Yes, whose privacy/security rights do you believe were violated?

First Name	**Last Name**

Who (or what ISDH program or business associate) do you believe violated your (or someone else's) privacy/security rights or committed another violation of the HIPAA regulations?

Person/Agency/Organization

Street Address ***(number and street)***	**City**
State / **ZIP Code**	**Telephone Number** ( )

When do you believe that the violation of HIPAA regulations occurred?
List Date(s)

Describe briefly what happened. How and why do you believe your (or someone else's) privacy/ security rights were violated? Or how and why you believe the HIPAA rules and regulations were violated? Please be as specific as possible. *(Attach additional pages as needed.)*

Please sign and date this complaint.

Signature	**Date** ***(month, day, year)***

(See Other Side)

Filing a complaint with the ISDH Privacy Officer or ISDH Security Officer is voluntary. However, without the information requested, the ISDH Privacy Officer or Security Officer may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for the investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the ISDH for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under the Privacy Rule. You are not required to use this form. You also may write a letter. Mail a complaint to the address at the top of this form.

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

First Name	**Last Name**
Home Telephone Number ( )	**Work Telephone Number** ( )

Street Address ***(number and street)***	**City**

State	**ZIP Code**	**E-Mail Address** ***(if available)***

Have you filed your complaint anywhere else? If so, please provide the following. ***(Attach additional pages as needed.)***

Person / Agency /Organization / Court Name(s)

Date(s) Filed ***(month, day, year)***	**Case Number(s) (*if known)***