TRI·CITY Mental Health

Confidential Client Information
See Welfare and Institutions Code 5328 HIPAA, CFR 45, Parts 160 and 164

HIPAA PRIVACY COMPLAINT FORM

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to complain about our privacy policies, procedures or actions. Generally, upon receipt of a complaint, the Privacy Officer will within 30 days of receiving the complaint attempt to come to an appropriate resolution. Tri-City Mental Health Center will not engage in any discriminatory or other retaliatory behavior against you because of this complaint. Please complete as much information as possible. If you have any questions regarding this form, you can contact our confidential Privacy Hotline at (909) 451-6428.

PERSON FILING THE PRIVACY COMPLAINT

Last Name	*First Name*	*M.I.*	*Medi-Cal #*	*Home Phone #*

Address	*Apt. #*	*City*	*State*	*Zip Code*

In the space provided below, please describe in detail your complaint. *(Please be as specific as possible with dates, times and why you believe that your health information privacy rights were violated; include the names, if any, of anyone in the office with whom you discussed this grievance. If more space is needed, continue the description on the other side of this form.)*

_____

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_____ _____
Client's Signature Date

_____ _____
Representative's Signature * Date

**** If signed by client's personal representative, state relationship and authority to do so in the space provided below:***

_____

Please complete and return this form to the reception staff or you can mail to: Attn: Privacy Officer
1717 N. Indian Hill Blvd Ste B Claremont, CA 91711

FOR OFFICE USE ONLY

Log Number: _____

Date Received by Privacy Officer: _____ _____

Comments: _____

_____

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HIPAA PRIVACY COMPLAINT FORM

DESCRIPTION OF PRIVACY COMPLAINT – *CONTINUED FROM SIDE 1*