HIPAA Complaint Template

Filing a complaint with the Defense Health Agency (DHA) is voluntary. However, without the information requested, DHA may be unable to proceed with your complaint. 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 investigation of information outside the Military Health System/TRICARE 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 HIPAA Privacy Rule.

Name (Last, First):	Home Phone:
Street Address:	Work Phone:
City: State: Zip Code:	Email Address:

1. Are you filing a complaint on behalf of another individual? Yes____No____
   If yes, please provide the following information:

Name of Individual (Last, First, Middle Initial):	Title/Rank:

2. Where did the violation occur? *Note: The violation must have originated at a healthcare facility under the Military Health System (i.e. Military Treatment Facility)*

Facility Name:	
Street Address:	City: State: Zip Code:

3. Please provide the name(s) of the individual(s) you believe caused the violation. *Note: The alleged violator(s) must be a workforce member of the Military Health System, including contractors and business associates.*

Name (Last, First, Middle Initial):	Title/Rank:

4. When did the violation occur? If exact date(s) is unknown, provide approximate timeframe.

_____

5. When were you made aware of the violation?

_____

6. What type of HIPAA violation occurred? Select all that are applicable:

_____Unauthorized access/viewing of health information

_____Unauthorized disclosure of health information

_____Loss of health information records

_____Retaliation for filing a previous complaint

_____Failure to receive requested health records or accounting of disclosures

_____Other (Explain:_____)

7. In the space below, please summarize the HIPAA violation(s) you believe occurred and if necessary attach any relevant details on the alleged incident:

Signature:_____ Date:_____