INDIANA UNIVERSITY SCHOOL OF DENTISTRY

Privacy Complaint Form

Please use this form to submit a complaint concerning the privacy and confidentiality of patient protected health information. You may also file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, OCR Complaint Portal at https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf or email OCR at OCRComplaint@hhs.gov. All complaints must be submitted in writing. You will not be penalized or retaliated against in any way for making a complaint to IUSD or the Department of Health and Human Services. To mail your completed complaint form to IUSD, please submit to: IUSD Privacy Officer, 1121 West Michigan Street, Indianapolis, IN 46202.

Your Name: ___________________________________________  Today's Date: ________________________

Your Address:_____________________________________________________________________________________

City:________________________ State:______________ Zip:________________________

Home Phone:_____________________________________ Work Phone:_____________________________________

Patient's Name:_________________________ Patient's Date of Birth: __________________________

Patient's Previous Name (if applicable): _____________________________________________________________

Patient's Address (if known):_______________________________________________________________________

City:________________________________ State:_________ Zip:________________________

Date of the incident that is the reason for this complaint:______________________________

Please give a brief explanation of your complaint. If you need additional space, please include a separate page. Please print or type a description of the nature of your complaint including dates, names and addresses of other persons who may be involved. Include copies of relevant material you may have.
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Complainant’s Signature                                          Date

Relationship to Patient

Updated 8/26/13 - OCA