DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights (OCR)

PATIENT SAFETY CONFIDENTIALITY COMPLAINT

Your First Name	Your Last Name
See Attached	
Home Phone *(Please include area code)*	Work Phone *(Please include area code)*
Street Address	City
State / ZIP	E-Mail Address *(If available)*

Who is the patient, provider or reporter who is identified in the information you believe was impermissibly disclosed?

First Name or Business Name	Last Name *(Leave blank if using Business Name to left)*

Who (e.g., provider, patient safety organization, other person) do you believe disclosed patient safety work product in violation of patient safety confidentiality?

Person/Agency/Organization

Street Address	City
State / ZIP	Phone

When do you believe that the impermissible disclosure occurred?
List Date(s)

Describe briefly what happened. How and why do you believe a person or organization impermissibly disclosed patient safety work product? Please be as specific as possible. Why do you believe the information disclosed is patient safety work product? *(Attach additional pages as needed)*

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

Signature	Date *(mm/dd/yyyy)*
	6.21.21

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act). We use it to investigate your complaint to see whether enforcement action is appropriate. The Privacy Act of 1974 protects the information submitted on this form. We may share your information with the Department of Justice or a court in the event of a lawsuit, with another agency that has jurisdiction over potential violations or reviews certifications of Patient Safety Organizations, or with others who help us carry out our work. Otherwise, OCR will not share your name or other identifying information about you unless you agree. You are not required to use this form. You may write a letter or submit a complaint electronically with the same information. You will find directions for submitting an electronic complaint on our web site at http://hhs.gov/ocr/privacy/psa/complaint/index.html. To mail a complaint see reverse page for OCR address.

PSC Graphics (301) 443-1090 EF

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? *(Check all that apply)*

☐ Braille ☐ Large print ☐ Cassette tape ☐ Computer diskette ☐ Electronic Mail ☐ TDD

☐ Sign language interpreter *(Specify language)*: _____

☐ Foreign language interpreter *(Specify language)*: _____

☐ Other *(Specify)*: _____

To help us better serve you, answer the following question.

HOW DID YOU LEARN ABOUT THE OFFICE FOR CIVIL RIGHTS?

☐ HHS Website / Internet Search ☐ Family / Friend / Associate ☐ Religious / Community Org ☐ Lawyer / Legal Org

☐ Phone Directory ☐ Employer ☐ Fed / State / Local Gov ☐ Healthcare Provider / Health Plan

☐ Conference / OCR Brochure ☐ Other *(Specify)*: _____

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

First Name	Last Name
Home Phone *(Please include area code)*	Work Phone *(Please include area code)*
Street Address	City
State / ZIP	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	Case Number(s) *(If known)*

To mail a complaint, please type or print, and return completed complaint to:

Office for Civil Rights
Department of Health and Human Services
Attn: Patient Safety Act
200 Independence Ave., SW, Rm. 509F
Washington, DC 20201
(202) 619-0403
TDD 1-800-537-7697
FAX: (202) 619-3818

To submit an electronic complaint, see our web site at *http://hhs.gov/ocr/privacy/psa/complaint/index.html*.

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 20 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201.