

Children's Hospital of Pittsburgh HEALTH INFORMATION PRIVACY COMPLAINT

Filing a privacy complaint with Children's Hospital of Pittsburgh (CHP) is voluntary. However, without the information requested below, CHP 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 (HIPAA). We will use the information you provide to help us determine if a violation has occurred. Information submitted on this form is treated confidentially. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside CHP for purposes associated with health information privacy compliance and as permitted by law. It is illegal for CHP 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 or contact Children's Hospital of Pittsburgh's Office of Corporate Compliance by phone at **(412) 692-7842 or the Compliance Helpline at 1-800-542-4841**. To mail a complaint see the address listed at the end of this form.

If you have questions about this form, please call Children's Hospital of Pittsburgh's Office of Corporate Compliance at (412) 692-7842 or 1-800-542-4841 (Compliance Helpline).

YOUR FIRST NAME

YOUR LAST NAME

STREET ADDRESS

CITY

STATE

ZIP

HOME PHONE

WORK PHONE *(if you would like us to contact you at work)*

E-MAIL ADDRESS *(if you would like us to contact you via e-mail)*

Are you filing this complaint for someone else? Yes No

If Yes, whose health information privacy rights do you believe were violated?

FIRST NAME

LAST NAME

Who (or what agency or organization, e.g., provider, health plan) do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

PERSON / AGENCY / ORGANIZATION

STREET ADDRESS

CITY

STATE

ZIP

When do you believe that the violation of health information privacy rights occurred?

LIST DATE(S) _____

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (If additional pages are needed, you must return the complaint to CHP in a separate envelope.)

Please sign and date this complaint.

DATE _____

SIGNATURE _____

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

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

Large Print

Cassette tape

Computer diskette

Electronic mail

Sign language interpreter (*specify language*): _____

Foreign language interpreter (*specify language*): _____

Other: _____

Have you filed your complaint anywhere else? (Either within CHP or elsewhere) If so, please provide the following. (Attach additional pages as needed)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S) _____

DATE(S) FILED _____

RESPONSE OR ACTION TAKEN OR PLANNED (*if known*) _____

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

**Children's Hospital of Pittsburgh
Office of Corporate Compliance
3705 Fifth Avenue
Pittsburgh, PA 15213**