Health Information Privacy Complaint

Your First Name _____ Your Last Name _____

Home Phone (Include area code) _____ Work Phone (Include area code) _____

Street address _____ City _____

State _____ Zip _____ E-mail address (If available) _____

Are you filing a 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 _____ Phone (Include area code) _____

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. (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)* _____

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The remaining information on this form is optional. Failure to answer these voluntary questions will not affect CareATC's obligation to investigate your complaint.

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

☐ Large Print ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

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

First Name _____ Last Name _____

Home Phone (Include area code) _____ Work Phone (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) _____

Dates(s) filed _____ Case number(s) (If known) _____

To submit a complaint, please type, print or sign the concern form to the CareATC Headquarters address below.

CareATC
Attn: Privacy Officer
4500 129th East Avenue, Suite 191
Tulsa, OK 74134
Phone: 918-779-7455
Email: dl-compliance@careatc.com