Attachment B

Section No.: 10.1.20

Kern Behavioral Health & Recovery Services

Privacy Complaint Form

The information you provide here will remain confidential to the extent possible, however, we may need to divulge the information to investigate your claim. Anyone may file a complaint. Members of the workforce may use this form to report violations of HIPAA by others in the workforce.

You may submit your complaint to:

CONFIDENTIAL
Privacy & Corporate Compliance Office
Kern Behavioral Health & Recovery Services
P.O Box 1000, Bakersfield, CA 93302
or
BHRSPrivacy@KernBHRS.org

1. Your Information		
Last Name:	First Name:	Middle Initial:
Adress:	City/State	Zip Code
Email Address:	Telephone Number:	Best way to reach you?
Best time to reach you?		

2. Consent To Disclosure Your Name (Optional)

Please select one of the following:

☐ I consent to my name being disclosed to investigate this complaint. KernBHRS will only divulge information about you in an investigation within legal limits.

☐ I do not consent to my name being disclosed. I realize that not being able to release my name may hinder the completion of an investigation.

3. Information About Your Complaint	
Name of the Organization you believe violated privacy/compliance regulation(s):	Name of person you believe violated privacy/compliance regulation(s):

Date you first noticed a possible violation:	Date(s) possible violation(s) occurred:

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Details of the Complaint:
I have reason to believe that one or more of the following has occurred:

- ☐ The organization/ person has inappropriately disclosed personal health information.
- ☐ The organization/ person has inappropriately used personal health information.
- ☐ The organization/ person has inappropriately disposed of personal health information.
- ☐ The organization/ person has inappropriately denied access to personal health information.
- ☐ The organization/ person has inappropriately denied an amendment to personal health information.
- ☐ The organization/ person has inappropriately denied a requested restriction to personal health information.
- ☐ The organization's privacy policies and/or procedures violate HIPAA requirements.
- ☐ Other: (be specific) _____

Please provide a detailed description of your complaint covering what, when, who, how, where, and, if you know, discuss the why of what happened. You may attach additional pages if needed.

Is/Are there witness(es)? ☐ Yes ☐ No

If yes, please provide the names, addresses and telephone numbers of your witness(s)below

Witness Name:	Address:	Telephone Number:

Witness Name:	Address:	Telephone Number:

4. Resolution of Your Complaint
Please describe how you believe this complaint could be resolved:

5. Your Signature	
Signature:	Date: