Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

HEALTH INFORMATION PRIVACY COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
(b)(6);(b)(7)(C)	(b)(6);(b)(7)(C)
HOME / CELL PHONE (Please include area code)	WORK PHONE (Please include area code)
(b)(6);(b)(7)(C)	

STREET ADDRESS	CITY
(b)(6);(b)(7)(C)	(b)(6);(b)(7)(C)

STATE	ZIP	E-MAIL ADDRESS (If available)
(b)(6);(b)(7)(C)	(b)(6);(b)(7)(C)	(b)(6);(b)(7)(C)

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

Planned Parenthood

STREET ADDRESS	CITY
1007 s Peoria ave	Tulsa

STATE	ZIP	PHONE (Please include area code)
Oklahoma	74133	(918) 587-1101

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

LIST DATE(S)

01/01/2017

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)

Employee, (b)(6);(b)(7)(C) at Planned Parenthood Tulsa Oklahoma used my medical records to harm, Bully and start rumors based on claims private about my medical records at the facility.

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)*
(b)(6);(b)(7)(C)	03/03/2017

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 authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. 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 the Department for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity 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 submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at: **www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.