




Chapter: Information Management & Technology  
Subject: CONFIDENTIALITY AND HIPAA PRIVACY COMPLAINTS

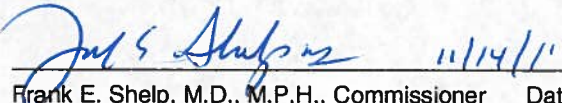
Attachments:

- Attachment A: Privacy Violation Report
- Attachment B: Privacy Complaint Report
- Attachment C: Health Information Privacy Complaint Form

Creation Date: November 8, 2011  
 Last Revision Date: December 2, 2011  
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Approved:

 11/10/11  
 Elizabeth Bentley Watson, Esq. Date  
 Privacy Officer

 11/14/11  
 Frank E. Shelp, M.D., M.P.H., Commissioner Date

**POLICY**

It is the policy of DBHDD that anyone may file a complaint relating to an individual's privacy rights, or the privacy policies or practices of DBHDD. Complaints made known to DBHDD will be investigated and resolved. DBHDD will not take any form of retaliatory action against any person or individual for filing a complaint.

**APPLICABILITY**

This policy is applicable to any facility or program that is operated by DBHDD, including the state office, regional offices, state operated DBHDD hospitals and any state operated community programs.

Providers operating with DBHDD by contract or letter of agreement who are also "covered entities" under HIPAA have an independent duty to receive and respond to privacy complaints as required by HIPAA and state regulations. This policy and associated forms are available as resources for providers, but DBHDD makes no representation or warranty that compliance with the provisions of this policy will ensure a provider's compliance with all applicable laws and regulations. Providers should seek their own legal counsel regarding compliance with laws and regulations on the subject matter of this policy.

**DEFINITIONS**

All defined terms used in this policy shall have the same meaning as defined in the Department of Behavioral Health and Developmental Disabilities' "Confidentiality and

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HIPAA” Policy #23-100. See also, Policy 23-102, “Reporting and Notification of Breaches of Confidentiality.”

## **PROCEDURES**

- A. Any person may file a complaint:
  - a. If he or she feels that DBHDD has violated an individual’s privacy rights;
  - b. If he or she feels that DBHDD has committed another type of violation of the HIPAA Privacy Rule or Security Rule;
  - c. If an individual requested access to or a copy of his or her clinical record and the request was denied;
  - d. If an individual requested an amendment of his or her clinical record and the request was denied;
  - e. About the privacy policies, practices, and procedures of DBHDD; OR
  - f. About DBHDD’s compliance with its privacy policies, practices and procedures.
  
- B. Complaints must:
  - a. be made in writing;
  - b. name the DBHDD facility, program, or regional office against which the complaint is lodged; AND
  - c. describe the acts or omissions which the complainant believes have violated the requirements of the Privacy or Security Rule.
  
- C. Complaints may be filed either directly to DBHDD or to the Secretary of the United States Department of Health and Human Services (HHS).
  
- D. Upon request, the DBHDD Office of Legal Services, a DBHDD hospital attorney, a Privacy Coordinator at the hospital or region, or the DBHDD Privacy Officer will provide forms and other information about the complaint process necessary to assist an individual wishing to file a complaint. DBHDD employees are not authorized to prepare complaints for anyone other than themselves. Complaints to DBHDD or any of its facilities, regions or state operated services may be made on forms used locally for filing Human Rights complaints, or on the Privacy Complaint Report form (Attachment B).
  
- E. The DBHDD Privacy Officer for DBHDD, and the Privacy Coordinator for the facility, program, or regional office, are designated as the persons responsible for receiving complaints filed against DBHDD. DBHDD maintains this designation within writing in this policy, in order to comply with the HIPAA Privacy Rule.
  
- F. If the complaint was made by someone other than the individual whose privacy rights are at issue, the individual’s guardian or agent in an Advance Directive, or

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the parent of a minor individual, then the Privacy Coordinator or Privacy Officer will determine whether the complainant is authorized to receive confidential and protected health information of the individual. If the complainant is not so authorized and the individual will not or cannot provide authorization for release of his/her information, correspondence with the complainant shall not disclose confidential protected health information of the individual. The complainant may be informed whether the complaint was resolved, and the general nature of resolution to the extent that disclosure of PHI is not necessary. When necessary, the Privacy Officer or the Office of Legal Services may provide guidance or assistance.

G. Complaints to DBHDD must be:

- a. Copied to the Privacy Coordinator of the facility, program, or regional office, as well as to the Human Rights Committee of the facility or program, AND
- b. Reported on the Privacy Complaint Report form (Attachment B) and sent to the DBHDD Privacy Officer at the following address:

Privacy Officer  
Department of Behavioral Health and Developmental Disabilities  
2 Peachtree Street NW  
Room 22.240  
Atlanta, Georgia 30303-3142

- c. Acknowledged in writing by the Privacy Coordinator if received originally by a facility, program, or region, or by the Privacy Officer if received originally by the Department. Although not required by the Privacy Rule, a written acknowledgement of receipt will be sent within ten (10) days of receipt, provided that adequate address information is available to permit the sending of a written acknowledgement.

H. The Privacy Coordinator for the facility, program or region (or where applicable, the Privacy Officer) reviews all privacy complaints within two business days of receipt to determine whether there may be an urgent need to notify the individual of a possible breach, pursuant to the procedures of DBHDD Policy 23-102, "Reporting and Notification of Breaches of Confidentiality."

I. Privacy complaints shall be investigated promptly by the facility, program or region. Complaints may be referred to the Human Rights Committee of a facility or program for investigation. Investigations shall be completed no later than 30 days following the date of the complaint.

J. The Privacy Officer of DBHDD may investigate or otherwise respond to complaints and recommend resolution where appropriate.

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- K. Following investigation, the facility, program or regional office shall complete a final report on the Privacy Complaint Report form (Attachment B), and report to the DBHDD Privacy Officer:
- a. The resolution or disposition of a complaint,
  - b. Whether a violation is discovered as the result of an investigation. (Submit the Privacy Violation Report, Attachment A), and
  - c. Any steps taken, such as to mitigate violations.
- L. Complaints received by DBHDD but alleging a violation by a contracted provider of DBHDD will be referred to the provider for investigation. The regional office or other contract manager should follow usual policy regarding review of the investigation, requiring corrective action as necessary, and other steps for assuring compliance with confidentiality and HIPAA requirements in the provider's contract or agreement.
- M. Though not required by the Privacy Rule, DBHDD will make available upon request sample forms and appropriate information to persons who wish to file complaints with the Secretary of HHS. Information on filing a complaint with the Secretary of HHS is available electronically at <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>  
A copy of the HHS complaint form is attached to this protocol (Attachment C) <http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf>
- N. A complaint may be filed with the Secretary of HHS at the following address:  
Office for Civil Rights  
U.S. Department of Health and Human Services  
Sam Nunn Atlanta Federal Center, Suite 16T70  
61 Forsyth Street, S.W.  
Atlanta, GA 30303-8909
- OR:  
Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F HHH Bldg.  
Washington, D.C. 20201
- O. Complaints filed directly with the Secretary of HHS must be filed within 180 days of the time the complainant became aware, or should have been aware, of the violation.
- P. If a DBHDD facility, program or regional office learns that a complaint has been made to the Secretary of HHS, staff shall:

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- a. Submit a Privacy Complaint Report (Attachment B) to the DBHDD Privacy Officer with all available information, and
  - b. Contact the DBHDD Privacy Officer for guidance as necessary in complying with the procedures for investigations by the Secretary of HHS, as set forth in 45 CFR Part 160, Subpart C, Compliance and Investigations, at 45 CFR §§ 160.300 et seq.
- Q.** DBHDD and its facilities, programs, and regional offices may not intimidate, threaten, coerce, harass, discriminate against, discipline, or take other retaliatory action against any individual or other person for that individual's or person's:
- a. filing a complaint with DBHDD or its facilities, programs, or regional offices; with HHS; or with a contracted provider or business associate of DBHDD;
  - b. testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under the Privacy Rule;
  - c. opposing any act or practice made unlawful by the HIPAA Privacy Rule, provided that the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involved a disclosure of PHI in violation of the Privacy Rule;  
OR
  - d. exercising any other right established by the Privacy Rule.
- R.** DBHDD may not require an individual to waive his or her rights under the HIPAA Privacy rule as a condition for the provision of treatment, payment, or eligibility for benefits.
- S.** DBHDD and its facilities, programs and regional offices must maintain records of complaints and their disposition for six (6) years, or longer according to other applicable authorities, following the disposition or last activity regarding the complaint.

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**LEGAL REFERENCES:**

1. 45 CFR §§ § 160.306, 160.316, 164.502(j), , 164.524(d)(2)(iii), 164.526(d)(1)(iv) 164.530(a),(d) and (e). See 45 CFR § 164.520.
2. OCGA §§ 37-3-149, 37-3-166, 37-4-109, 37-4-125, 37-7-149, and 37-7-166.

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES  
PRIVACY VIOLATION REPORT**

**DATE:** \_\_\_\_\_

**TO:** Privacy Officer  
Department of Behavioral Health and Developmental Disabilities  
2 Peachtree Street NW, Room 22.240  
Atlanta, GA 30303  
[hipaa@dbhdd.ga.gov](mailto:hipaa@dbhdd.ga.gov)

**THROUGH:** \_\_\_\_\_  
Facility/Program Administrator Title

**FROM:** **DBHDD Facilities and Offices:**  
\_\_\_\_\_  
Privacy Coordinator Coordinator's Title and Work Unit  
\_\_\_\_\_  
Facility Phone Number

**OR: Business Associates:**  
\_\_\_\_\_  
Name of Business Associate Address City, State, Zip Code  
\_\_\_\_\_  
Contact Person's Name & Title Contact Person's Phone(s) & e-mail

**Please report potential violations of the HIPAA Privacy Rule using this form. Potential violations include unauthorized acquisition, access, use or disclosure of Protected Health Information (PHI).**

As required by DBHDD Privacy Policies, I hereby submit the following information regarding a possible violation of the HIPAA Privacy Rule.

**ALLEGED VIOLATION**

Initial Report  Yes  No If this is an addendum, date of Initial Report: \_\_\_\_\_

Date of Discovery \_\_\_\_\_

Actual Occurrence date, if known \_\_\_\_\_

Number of individuals whose PHI was disclosed or involved: \_\_\_\_\_

**Type of Violation:** (check all that apply)

- Theft  Loss  Improper Disposal  Hacking/IT incident  Unauthorized Access/Disclosure  
 Unknown  Currently Under Investigation

**Location(s) of violation:** (check all that apply)

- Laptop  Desktop Computer  Network Server  E-mail  Other portable electronic device  
 Electronic Medical Record  Paper  Currently Under Investigation  Other: \_\_\_\_\_

**Type of PHI involved:** (check all that apply)

SSN?  Yes  No

DOB?  Yes  No

Demographic information  Yes  No Describe type: \_\_\_\_\_

Financial information  Yes  No Describe type: \_\_\_\_\_

Clinical information  Yes  No Describe type: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_ Currently Under Investigation

**Description of the violation:** Include location of violation, description of how the violation occurred, additional information regarding type of violation, type of media, and type of PHI involved. *Attach additional sheets if necessary.*

**Safeguards in place prior to violation:** (check all that apply)

- Firewalls    Packet Filtering (router-based)    Secure Browser Sessions    Strong Authentication  
 Encrypted Wireless    Physical Security    Logical Access Control    Anti-virus Software  
 Intrusion Detection    Biometrics    Currently Under Investigation    Other: \_\_\_\_\_

Violator's Name, if known \_\_\_\_\_

Violator's Title, if known \_\_\_\_\_

Number of previous similar violations for this violator \_\_\_\_\_

Number of previous similar violations within this work unit \_\_\_\_\_

**ACTIONS TAKEN** (check all that apply)

- Security and/or Privacy Safeguards    Mitigation    Employee Sanctions    Policies and Procedures  
 Currently Under Investigation    Other: \_\_\_\_\_

Describe actions taken to mitigate any potentially harmful effects of the violation. *Attach additional sheets if necessary.*

Describe all actions taken to reduce the possibility of recurrence of this violation within this work unit. *Attach additional sheets if necessary.*

Has this incident been determined to be a violation?    Yes    No

**NOTIFICATION (IF REQUIRED)**

If a violation, has violation been determined to constitute a breach?    Yes    No

Date of determination of breach: \_\_\_\_\_ By whom: \_\_\_\_\_

Notice of Breach to Individual(s) affected (if applicable): Individual: \_\_\_\_\_ Date: \_\_\_\_\_

Address or contact information where notification made: \_\_\_\_\_

Was Substitute Notice required?    Yes    No

To whom: \_\_\_\_\_ Relationship to Individual: \_\_\_\_\_

Address or contact information: \_\_\_\_\_

Media Notice (if required): Date: \_\_\_\_\_ Time: \_\_\_\_\_

Media Name(s): \_\_\_\_\_

Contact Person Name: \_\_\_\_\_ Contact Person phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Has a complaint been received or stated regarding this violation?    Yes    No   If so, please attach a copy.

Has the complaint been resolved?    Yes    No   If so, please attach a copy of relevant documents



Attach additional sheets if necessary.	
If resolved, state resolution and other actions taken.	
<b>For all complaints, whether violation is found or not, complete the following:</b>	
Complainant notified?***	
If yes, date of notice.	
Individual notified?	
If yes, date of notice.	

\*\*\*Before notifying a complainant who is not the individual whose privacy rights are at issue, confirm whether the individual's confidential and protected health information may be released to the complainant. Contact Legal Services for assistance if necessary.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE FOR CIVIL RIGHTS (OCR)

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



## HEALTH INFORMATION PRIVACY COMPLAINT

YOUR FIRST NAME		YOUR LAST NAME	
HOME PHONE (Please include area code)		WORK PHONE (Please include area code)	
STREET ADDRESS		CITY	
STATE	ZIP	E-MAIL ADDRESS (If available)	

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	PHONE (Please 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)

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](http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html). To mail a complaint see reverse page for OCR Regional addresses.

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 OCR 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: \_\_\_\_\_

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)
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To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).

- ETHNICITY (select one)                      RACE (select one or more)  
 Hispanic or Latino                       American Indian or Alaska Native     Asian                       Native Hawaiian or Other Pacific Islander  
 Not Hispanic or Latino                       Black or African American                       White                       Other (specify): \_\_\_\_\_

PRIMARY LANGUAGE SPOKEN (if other than English) \_\_\_\_\_

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): \_\_\_\_\_

To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.

<b>Region I - CT, ME, MA, NH, RI, VT</b> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<b>Region V - IL, IN, MI, MN, OH, WI</b> Office for Civil Rights, DHHS 233 N. Michigan Ave. - Suite 240 Chicago, IL 60601 (312) 886-2359; (312) 353-5693 (TDD) (312) 886-1807 FAX	<b>Region IX - AZ, CA, HI, NV, AS, GU,          The U.S. Affiliated Pacific Island Jurisdictions</b> Office for Civil Rights, DHHS 90 7th Street, Suite 4-100 San Francisco, CA 94103 (415) 437-8310; (415) 437-8311 (TDD) (415) 437-8329 FAX
<b>Region II - NJ, NY, PR, VI</b> Office for Civil Rights, DHHS 26 Federal Plaza - Suite 3312 New York, NY 10278 (212) 264-3313; (212) 264-2355 (TDD) (212) 264-3039 FAX	<b>Region VI - AR, LA, NM, OK, TX</b> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<b>Region III - DE, DC, MD, PA, VA, WV</b> Office for Civil Rights, DHHS 150 S. Independence Mall West - Suite 372 Philadelphia, PA 19106-3499 (215) 861-4441; (215) 861-4440 (TDD) (215) 861-4431 FAX	<b>Region VII - IA, KS, MO, NE</b> Office for Civil Rights, DHHS 601 East 12th Street - Room 248 Kansas City, MO 64106 (816) 426-7277; (816) 426-7065 (TDD) (816) 426-3686 FAX	
<b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b> Office for Civil Rights, DHHS 61 Forsyth Street, SW. - Suite 16T70 Atlanta, GA 30303-8909 (404) 562-7886; (404) 562-7884 (TDD) (404) 562-7881 FAX	<b>Region VIII - CO, MT, ND, SD, UT, WY</b> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<b>Region X - AK, ID, OR, WA</b> Office for Civil Rights, DHHS 2201 Sixth Avenue - Mail Stop RX-11 Seattle, WA 98121 (206) 615-2290; (206) 615-2296 (TDD) (206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 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. **Please do not mail this complaint form to this address.**



## COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, [\*Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights\*](#) and [\*Protecting Personal Information in Complaint Investigations\*](#) for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.



- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.
- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

**CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

**CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*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.*

Name (Please print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_



## NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

### **Privacy Act**

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:

- (i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
- (ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
- (iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
- (iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
- (v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.



OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

- (i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
- (ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
- (iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
- (iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

#### **Freedom of Information Act**

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

#### **Fraud and False Statements**

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".



## **PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS**

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

### **HOW DOES OCR PROTECT MY PERSONAL INFORMATION?**

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

### **CAN I SEE MY OCR FILE?**

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

### **CAN OCR GIVE MY FILE TO ANY ONE ELSE?**

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

### **CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?**

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,



as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed \$100.00.

If you have any questions about this complaint and consent package,  
Please contact OCR at <http://www.hhs.gov/ocr/office/about/contactus/index.html>

*OR*

Contact your OCR Regional Office  
(see Regional Office contact information on page 2 of the Complaint Form)