



Kern Behavioral Health & Recovery Services

Attachment B

Section No.: 10.1.20

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:
Address:	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):
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Date you first noticed a possible violation:	Date(s) possible violation(s) occurred:
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Privacy Complaint Form

Details of the Complaint: I have reason to believe that one or more of the following has occurred: <input type="checkbox"/> The organization/ person has inappropriately disclosed personal health information. <input type="checkbox"/> The organization/ person has inappropriately used personal health information. <input type="checkbox"/> The organization/ person has inappropriately disposed of personal health information. <input type="checkbox"/> The organization/ person has inappropriately denied access to personal health information. <input type="checkbox"/> The organization/ person has inappropriately denied an amendment to personal health information. <input type="checkbox"/> The organization/ person has inappropriately denied a requested restriction to personal health information. <input type="checkbox"/> The organization's privacy policies and/or procedures violate HIPAA requirements. <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
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4. Resolution of Your Complaint

Please describe how you believe this complaint could be resolved:

5. Your Signature

Signature:	Date:
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