

English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по-русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE FOR CIVIL RIGHTS (OCR)  
HEALTH INFORMATION PRIVACY COMPLAINT**

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



YOUR FIRST NAME (b)(6);(b)(7)(C)		YOUR LAST NAME (b)(6);(b)(7)(C)	
HOME / CELL PHONE (Please include area code) (b)(6);(b)(7)(C)		WORK PHONE (Please include area code)	
STREET ADDRESS (b)(6);(b)(7)(C)		CITY (b)(6);(b)(7)(C)	
STATE (b)(6);(b)(7)(C)	ZIP (b)(6);(b)(7)(C)	E-MAIL ADDRESS (If available) (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  
 400 West 30th St.  
 CITY  
 Los Angeles  
 STATE  
 California  
 ZIP  
 90007  
 PHONE (Please include area code)  
 (213) 284-3200

**When do you believe that the violation of health information privacy rights occurred?**  
 LIST DATE(S)  
 01/19/2017

**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)**

I received medical insurance (medicare) forms from 5 other people including myself which include names, DOB, insurance ID number, address, diagnosis codes, and cost of treatments. The forms were sent from multiple planned parenthood locations to Hispanic Physicians IPA in Beverly Hills, CA.

What happened was, the envelope was too big so instead of the physician's name and address being in the envelope window, my form which had my name and address took it's place. This seems grossly negligent. I would not want my information in the hands of someone else.

**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  
 (b)(6);(b)(7)(C)

DATE (mm/dd/yyyy)  
 01/20/2017

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](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 us 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 / CELL 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.**

<p align="center"><b>Region I - CT, ME, MA, NH, RI, VT</b></p> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<p align="center"><b>Region V - IL, IN, MI, MN, OH, WI</b></p> 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	<p align="center"><b>Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions</b></p> 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
<p align="center"><b>Region II - NJ, NY, PR, VI</b></p> 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	<p align="center"><b>Region VI - AR, LA, NM, OK, TX</b></p> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<p align="center"><b>Region III - DE, DC, MD, PA, VA, WV</b></p> 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	<p align="center"><b>Region VII - IA, KS, MO, NE</b></p> 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	
<p align="center"><b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b></p> 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	<p align="center"><b>Region VIII - CO, MT, ND, SD, UT, WY</b></p> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<p align="center"><b>Region X - AK, ID, OR, WA</b></p> Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (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 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: 01/20/2017

*\*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)

HEALTH INSURANCE  
APPROVED BY NAME

HISPANIC PHYSICIANS IPA  
P O BOX 10718  
BEVERLY HILLS, CA 90213

RGARCIA  
61047536

TRANS IPA  
CA 90213

RGARCIA  
61047531

INSURANCE CLAIM FOR  
FILING CLAIMS FOR SUBMITTED TO



HEALTH INSURANCE CLAIM FORM  
APPROVED BY NATIONAL EMPLOYER CLAIM COMMITTEE (NECC) 2012

HISPANIC PHYSICIANS IPA  
P O BOX 10718  
BEVERLY HILLS, CA 90213

RGARCIA  
61047532

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HEALTH INSURANCE CLAIM FORM

1. MEMBER'S SOCIAL SECURITY NUMBER: 01 17 1977

2. MEMBER'S DATE OF BIRTH: 01 17 1977

3. MEMBER'S SIGNATURE: (b)(6);(b)(7)(C)

4. EMPLOYER'S SIGNATURE: (b)(6);(b)(7)(C)

5. DATE OF SIGNATURE: 11/28/2016

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93. SIGNATURE ON FILE: (b)(6);(b)(7)(C)

94. SIGNATURE ON FILE: (b)(6);(b)(7)(C)

95. SIGNATURE ON FILE: (b)(6);(b)(7)(C)

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97. SIGNATURE ON FILE: (b)(6);(b)(7)(C)

98. SIGNATURE ON FILE: (b)(6);(b)(7)(C)

99. SIGNATURE ON FILE: (b)(6);(b)(7)(C)

100. SIGNATURE ON FILE: (b)(6);(b)(7)(C)

(b)(6);(b)(7)(C)

(b)(6);(b)(7)(C)

PLANNED PARENTHOOD LOS ANGELES  
400 WEST PARENTHOOD LOS ANGELES  
LOS ANGELES, CA 90007  
(213) 284-3200

FIRST CLASS

20



U.S. POSTAGE  
ZIP 90007  
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HISPANIC PHYSICIANS IPA  
P O BOX 10718  
BEVERLY HILLS, CA 90213

(b)(6);(b)(7)(C)

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SHIP TO REQUIRED  
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(b)(6);(b)(7)(C)

CLASS MAIL

FIKS



## DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

February 8, 2017

Planned Parenthood  
400 West 30th St.  
Los Angeles, CA 90007  
Attn: Privacy Officer

Re: OCR Transaction Number: CU-17-259800  
(b)(6);(b)(7)(C) vs Planned Parenthood

Dear Privacy Officer:

On January 20, 2017, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received a complaint alleging that Planned Parenthood, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164, Subparts A and E, the Privacy Rule). Specifically, the complainant, (b)(6);(b)(7)(C), alleges that on January 19, 2017, Planned Parenthood included Medicare forms for several other unrelated patients that included their information in the mail she received. This allegation could reflect a violation of 45 C.F.R. §§ 164.502(a) and 164.530(c).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also enforces Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

Generally, the Privacy Rule permits a covered entity to make disclosures of protected health information (PHI) for a permitted purpose, through a variety of means, such as by mail or facsimile machine, as long as the covered entity, when doing so, uses reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of the PHI. See 45 C.F.R. § 164.502(a). These safeguards may vary depending on the mode of communication used. For example, when faxing PHI to a telephone number that is not used regularly, a reasonable safeguard may involve a covered entity first confirming the fax number with the intended recipient of the fax.

In this matter, the complainant alleges that PHI was impermissibly disclosed either through the mail or by fax. Pursuant to its authority under 45 C.F.R. §§ 160.304(a) and (b), OCR has determined to resolve this matter through the provision of technical assistance to Planned Parenthood. To that end, OCR has enclosed a checklist of reminders on how to safely use the mail or fax machines when sending PHI.

You are encouraged to review these materials closely and to share them with your staff as part of the Health Insurance Portability and Accountability Act (HIPAA) training you provide to your workforce. You are also encouraged to assess and determine whether there may have been an incident of noncompliance as alleged by the complainant in this matter, and, if

so, to take the steps necessary to ensure such noncompliance does not occur in the future. Please contact OCR if you need further information regarding the allegations in this matter. Should OCR receive a similar allegation of noncompliance against Planned Parenthood in the future, OCR may initiate an investigation of that matter.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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 you have any questions about this matter, please contact Investigator, Michelle Summers, at (202) 205-5829 or (202) 619-3257 (TDD).

Sincerely,

A handwritten signature in black ink that reads "Peggy Lee". The signature is written in a cursive, flowing style.

Peggy Lee  
Interim Director CCMO

Enclosure: Checklist

**Q: May a physician’s office or health plan use mail or fax to send patient medical information?**

A: Yes. Where the Privacy Rule allows covered health care providers, health plans, or health care clearinghouses to share protected health information with another organization or with the individual, they may use a variety of means to deliver the information, as long as they use reasonable safeguards when doing so. When the communications are in writing, the patient information may be sent by mail, fax, or other means of reliable delivery.

The Privacy Rule requires that covered entities apply reasonable safeguards when making these communications to protect the patient information from inappropriate use or disclosure to unauthorized persons. These safeguards will vary depending on the mode of communication used. For example, when mailing patient information, reasonable safeguards would include checking to see that the name and address of the recipient are correct and current and that only the minimum amount of patient information is showing on the outside of the envelope to ensure proper delivery to the intended recipient. When faxing protected health information to a telephone number that is not regularly used, a reasonable safeguard would include first confirming the fax number with the intended recipient. Similarly, a covered entity may pre-program frequently used numbers directly into the fax machine to avoid misdirecting the information to someone who is not the intended recipient. The following checklists provide guidance on reasonable safeguards that a covered health care provider, health plan, or health care clearinghouse may put in place to protect patient information from being impermissibly disclosed during (1) mailing and (2) faxing. See 45 C.F.R. § 164.530(c).

**MAILING CHECKLIST**

<input type="checkbox"/>	Carefully check name and address of intended recipient. Many names are similar; make sure you have the correct name for the intended recipient on the envelope. Make sure the address on the envelope matches the correct address of the intended recipient.
<input type="checkbox"/>	Carefully check the contents of the envelope before sealing. Make sure the contents may be permissibly disclosed to the intended recipient or properly relate to the individual. Check all pages to make sure records or material related to other individuals are not mistakenly included in the envelope.
<input type="checkbox"/>	Check the information showing on the outside of the envelope or through the address window. Make sure identifying information that is not necessary to ensure proper delivery is not disclosed.
<input type="checkbox"/>	When doing mass mailings, do test runs to ensure the system is properly performing and check at least a sample of the mailings for the accuracy of name and address of the intended recipients and the correct contents, as indicated above, before sending.
<input type="checkbox"/>	Have policies and procedures in place to safeguard protected health information that is mailed, including processes to act promptly on (1) name and address changes to ensure corrections are made in all the relevant records; and (2) reports of misdirected mail to identify the cause and take steps to prevent future incidents.
<input type="checkbox"/>	Train staff on the mailing procedures that your organization has put in place to safeguard protected health information during mailing. Update the training periodically and be sure to train new staff.

### FAXING CHECKLIST

<input type="checkbox"/>	Carefully check the fax number to make sure you have the correct number for the intended recipient. When manually entering the number, check to see that it has been entered correctly before sending.
<input type="checkbox"/>	Confirm fax number with the intended recipient when faxing to this party for the first time or if the fax number is not regularly used.
<input type="checkbox"/>	Program regularly used numbers into fax machines. Check to make sure you are selecting the preprogrammed number for the correct party before sending.
<input type="checkbox"/>	Update fax numbers promptly upon receipt of notification of correction or change. Have procedures for deleting outdated or unused numbers which are preprogrammed into the fax machine.
<input type="checkbox"/>	Locate fax machines in areas where access can be monitored and controlled and avoid leaving patient information on fax machines after sending.
<input type="checkbox"/>	Have policies and procedures in place to safeguard protected health information that is faxed, including processes to act promptly on (1) changes in fax numbers to ensure corrections are made in all the relevant records; and (2) reports of a misdirected fax to identify the cause and take steps to prevent future incidents, including revising the organization's policies and procedures.
<input type="checkbox"/>	Train staff on the policies and procedures for the proper use of fax machines that your organization has put in place to safeguard protected health information during faxing. Update the training periodically and be sure to train new staff.





DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
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Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

February 8, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: CU-17-259800

(b)(6);(b)(7)(C) vs Planned Parenthood

Dear (b)(6);(b)(7)(C)

On January 20, 2017, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received your complaint alleging that Planned Parenthood, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164, Subparts A and E, the Privacy Rule). Specifically, you allege that on January 19, 2017, Planned Parenthood included Medicare forms for several other unrelated patients that included their information in the mail you received. This allegation could reflect a violation of 45 C.F.R. §§ 164.502(a) and 164.530(c).

Thank you for bringing this matter to OCR's attention. Your complaint plays an integral part in OCR's enforcement efforts.

OCR enforces the Privacy, Security, and Breach Notification Rules, and also enforces Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

The Privacy Rule allows health care providers and health plans to share protected health information (PHI) for permitted purposes using the mail or fax, as long as they use reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of the PHI. See 45 C.F.R. § 164.502(a). These safeguards may vary depending on the mode of communication used. For example, when faxing PHI to a telephone number that is not used regularly, a reasonable safeguard may involve a covered entity first confirming the fax number with the intended recipient of the fax.

We have carefully reviewed your complaint against Planned Parenthood and have determined to resolve this matter through the provision of technical assistance to Planned Parenthood. Should OCR receive a similar allegation of noncompliance against Planned Parenthood in the future, OCR may initiate an investigation of that matter.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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 you have any questions about this matter, please contact Centralized Case Management Operations at (800) 368-1019 or (202) 619-3257 (TDD).

Sincerely,



Peggy Lee  
Interim Director CCMO

English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по-русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE FOR CIVIL RIGHTS (OCR)  
HEALTH INFORMATION PRIVACY COMPLAINT**

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



YOUR FIRST NAME (b)(6);(b)(7)(C)		YOUR LAST NAME (b)(6);(b)(7)(C)	
HOME / CELL PHONE (Please include area code) (b)(6);(b)(7)(C)		WORK PHONE (Please include area code)	
STREET ADDRESS (b)(6);(b)(7)(C)		CITY (b)(6);(b)(7)(C)	
STATE (b)(6);(b)(7)(C)	ZIP (b)(6);(b)(7)(C)	E-MAIL ADDRESS (If available) (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 219 E main street		CITY Missoula
STATE Montana	ZIP 59802	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)**

I was informed everything was confidential, I had even confirmed so numerous times with the doctor helping me through the situation. My family was not informed but DFS was told everything over the phone. I feel as though my rights were violated by A) having been shared over the phone when the DFS worker could have been anybody and B) I never signed any papers saying it was OK for them to be told my situation when even my family was not informed.

**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 (b)(6);(b)(7)(C)	DATE (mm/dd/yyyy) 02/01/2017
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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 us 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 / CELL 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.**

<p align="center"><b>Region I - CT, ME, MA, NH, RI, VT</b></p> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<p align="center"><b>Region V - IL, IN, MI, MN, OH, WI</b></p> 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	<p align="center"><b>Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions</b></p> 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
<p align="center"><b>Region II - NJ, NY, PR, VI</b></p> 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	<p align="center"><b>Region VI - AR, LA, NM, OK, TX</b></p> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<p align="center"><b>Region III - DE, DC, MD, PA, VA, WV</b></p> 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	<p align="center"><b>Region VII - IA, KS, MO, NE</b></p> 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	
<p align="center"><b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b></p> 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	<p align="center"><b>Region VIII - CO, MT, ND, SD, UT, WY</b></p> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<p align="center"><b>Region X - AK, ID, OR, WA</b></p> Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (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 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: 02/01/2017

\*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)



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



YOUR FIRST NAME, YOUR LAST NAME, HOME / CELL PHONE, WORK PHONE, STREET ADDRESS, CITY, STATE, ZIP, E-MAIL ADDRESS

Are you filing this complaint for someone else? 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

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

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.

**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 us 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 / CELL 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)
---------------	---------------------------

**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.**

<p align="center"><b>Region I - CT, ME, MA, NH, RI, VT</b></p> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<p align="center"><b>Region V - IL, IN, MI, MN, OH, WI</b></p> 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	<p align="center"><b>Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions</b></p> 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
<p align="center"><b>Region II - NJ, NY, PR, VI</b></p> 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	<p align="center"><b>Region VI - AR, LA, NM, OK, TX</b></p> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<p align="center"><b>Region III - DE, DC, MD, PA, VA, WV</b></p> 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	<p align="center"><b>Region VII - IA, KS, MO, NE</b></p> 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	
<p align="center"><b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b></p> 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	<p align="center"><b>Region VIII - CO, MT, ND, SD, UT, WY</b></p> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<p align="center"><b>Region X - AK, ID, OR, WA</b></p> Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (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 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: 03/03/2017

\*Please sign and date 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".





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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.

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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)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

March 14, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: CU-17-263755

(b)(6);(b)(7)(C)

vs. Planned Parenthood

Dear (b)(6);(b)(7)(C)

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination, as stated in this letter, applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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.

We regret we are unable to assist you further. Thank you.

Sincerely,

Timothy Noonan  
Acting Director, CCMO

English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по-русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE FOR CIVIL RIGHTS (OCR)  
HEALTH INFORMATION PRIVACY COMPLAINT**

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



YOUR FIRST NAME <u>(b)(6);(b)(7)(C)</u>		YOUR LAST NAME <u>(b)(6);(b)(7)(C)</u>	
HOME / CELL PHONE (Please include area code) <u>(b)(6);(b)(7)(C)</u>		WORK PHONE (Please include area code)	
STREET ADDRESS <u>(b)(6);(b)(7)(C)</u>		CITY <u>(b)(6);(b)(7)(C)</u>	
STATE <u>(b)(6);(b)(7)(C)</u>	ZIP <u>(b)(6);(b)(7)(C)</u>	E-MAIL ADDRESS (If available) <u>(b)(6);(b)(7)(C)</u>	

**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 <u>160 Stone Street</u>		CITY <u>Watertown</u>
STATE <u>New York</u>	ZIP <u>13601</u>	PHONE (Please include area code) <u>(315) 788-8065</u>

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

LIST DATE(S)  
09/12/2016, 03/03/2017

**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)**

I received an anonymous letter in which some medical information was brought up in detail. I have not shared this information and this individual mentioned that he/she had gone to a friend and done some digging into my medical history. I believe I know who the individual is. The information was released between October 2016 and March 3, 2017.

**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 <u>(b)(6);(b)(7)(C)</u>	DATE (mm/dd/yyyy) <u>03/12/2017</u>
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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 us 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 / CELL 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)
---------------	---------------------------

**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.**

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## COMPLAINANT CONSENT FORM

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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: 03/12/2017

\*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)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

March 17, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: CU-17-264570

(b)(6);(b)(7)(C)

vs. Planned Parenthood

Dear (b)(6);(b)(7)(C)

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination, as stated in this letter, applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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.

We regret we are unable to assist you further. Thank you.

Sincerely,

Timothy Noonan  
Acting Director, CCMO

English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



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



YOUR FIRST NAME, YOUR LAST NAME, HOME / CELL PHONE, WORK PHONE, STREET ADDRESS, CITY, STATE, ZIP, E-MAIL ADDRESS

Are you filing this complaint for someone else? 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

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

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.

**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 us 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 / CELL 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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**How did you learn about the Office for Civil Rights?**

- HHS Website/Internet Search     
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**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: 03/18/2017

*\*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:



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- (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)

On 04/18/2015 I went to have a surgical procedure at Planned Parenthood. I chose to have it there because its a place that strongly advocates women's rights. After I finished with the procedure, I went home and that was it. On 10/08/16 someone told me that they found out about my procedure through a Planned Parenthood employee. I was shocked because I have no friends/relatives that works or worked at planned parenthood. I chose to have the procedure not because I wanted to but because I wasn't ready to deal with the lifelong obligations that it requires. After the procedure I went through a depressed period and was ashamed. So when I found out someone knew about it I was disappointed with Planned Parenthood and felt like they weren't teaching their employees about HIPAA. I now have to deal with the fact that my private health informations are no longer private. This is something I wanted to put behind me and move forward but instead, I am constantly reminded of it and that person is always threatening to tell other people about my "secret". So far 3 people whom I've told nothing to (possibly more ) now knows about something I never wanted anyone to know, because Planned Parenthood failed to protect my privacy. I'm filing the complaint because I feel like Planned Parenthood needs to make sure their employees knows how important it is to follow the HIPAA guidelines. Hopefully this complaint will help other patients so they don't go through what I'm currently going through.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

March 28, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: CU-17-265153

(b)(6);(b)(7)(C) vs. Planned Parenthood

Dear (b)(6);(b)(7)(C)

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination, as stated in this letter, applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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.

We regret we are unable to assist you further. Thank you.

Sincerely,

Timothy Noonan  
Acting Director, CCMO



English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по-русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE FOR CIVIL RIGHTS (OCR)  
HEALTH INFORMATION PRIVACY COMPLAINT**

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



YOUR FIRST NAME (b)(6);(b)(7)(C)		YOUR LAST NAME (b)(6);(b)(7)(C)	
HOME / CELL PHONE (Please include area code) (b)(6);(b)(7)(C)		WORK PHONE (Please include area code)	
STREET ADDRESS (b)(6);(b)(7)(C)		CITY (b)(6);(b)(7)(C)	
STATE (b)(6);(b)(7)(C)	ZIP (b)(6);(b)(7)	E-MAIL ADDRESS (If available) (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
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**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 San Rafael

STREET ADDRESS 2 H Street		CITY San Rafael
STATE California	ZIP 94901	PHONE (Please include area code) (415) 459-4907

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

LIST DATE(S)

06/06/2017

**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)**

I just opened up a bag in which my medication was in, that I was given at the San Rafael Planned Parenthood clinic yesterday afternoon. There is someone else's medication in it - full name, Medical Record number and DOB. This obviously means she has my medication, and is aware of my full name, Medical Record number and DOB. Considering this medication is for something very sensitive and I was promised privacy in the matter, I am beyond nervous and anxious about someone else having/knowing my full name, Medical Record number, DOB, and the type of medication I was prescribed.

**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 (b)(6);(b)(7)(C)	DATE (mm/dd/yyyy) 06/07/2017
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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 us 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 / CELL 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.**

<p align="center"><b>Region I - CT, ME, MA, NH, RI, VT</b></p> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<p align="center"><b>Region V - IL, IN, MI, MN, OH, WI</b></p> 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	<p align="center"><b>Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions</b></p> 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
<p align="center"><b>Region II - NJ, NY, PR, VI</b></p> 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	<p align="center"><b>Region VI - AR, LA, NM, OK, TX</b></p> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<p align="center"><b>Region III - DE, DC, MD, PA, VA, WV</b></p> 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	<p align="center"><b>Region VII - IA, KS, MO, NE</b></p> 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	
<p align="center"><b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b></p> 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	<p align="center"><b>Region VIII - CO, MT, ND, SD, UT, WY</b></p> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<p align="center"><b>Region X - AK, ID, OR, WA</b></p> Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (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 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: 06/07/2017

\*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);
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- (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.
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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;
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- (iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
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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.

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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".



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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.

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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.

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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)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

July 14, 2017

Planned Parenthood of San Rafael  
2 H Street  
San Rafael, CA 94901

Re: OCR Transaction Number: 17-272773

Dear Privacy Officer:

On June 7, 2017, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received your complaint alleging that Planned Parenthood of San Rafael, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164, Subparts A and E, the Privacy Rule). Specifically, the complainant, (b)(6);(b)(7) (b)(6);(b)(7) alleges that on June 6, 2017, Planned Parenthood of San Rafael located at 2 H Street, San Rafael, CA 94901, provided her with the prescription order of another patient, in error. This allegation could reflect a violation of 45 C.F.R. §§ 164.502(a) and 164.530(c).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also enforces Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

Generally, the Privacy Rule permits a covered entity to make disclosures of protected health information (PHI) for a permitted purpose, through a variety of means as long as the covered entity, when doing so, uses reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of the PHI. See 45 C.F.R. § 164.502(a). These safeguards may vary depending on the mode of communication used. When providing PHI to individuals in person, a reasonable safeguard may involve both verifying the identity of the individual to whom the PHI is being provided, and ensuring that the PHI provided does not inadvertently include PHI of other individuals.

Pursuant to its authority under 45 C.F.R. §§ 160.304(a) and (b), OCR has determined to resolve this matter informally through the provision of technical assistance to the covered entity. To that end, OCR has enclosed information on how to safeguard PHI.

You are encouraged to review these materials closely and to share them with your staff as part of the Health Insurance Portability and Accountability Act (HIPAA) training you provide to your workforce. You are also encouraged to assess and determine whether there may have been an incident of noncompliance as alleged by the complainant in this matter, and, if so, to take the steps necessary to ensure such noncompliance does not occur in the future. Please contact OCR if you need further information regarding the allegations in this matter. Should OCR receive a similar allegation of noncompliance against the covered entity in the future, OCR may initiate a formal investigation of that matter.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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 you have any questions regarding this matter, please contact Evita Jones, Investigator, at (202) 260-2194 (Voice) or (202) 619-3257 (TDD).

Sincerely,

A handwritten signature in black ink, appearing to read "T. Noonan". The signature is fluid and cursive, with a large initial "T" and a long, sweeping underline.

Timothy Noonan  
Acting Director, CCMO

Enclosures: technical assistance materials

## Reasonable Safeguards

### 45 C.F.R. § 164.530 (c)

A covered entity must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures. *See* 45 C.F.R. §164.530 (c). It is not expected that a covered entity's safeguards guarantee the privacy of protected health information from any and all potential risks. Reasonable safeguards will vary from covered entity to covered entity depending on factors, such as the size of the covered entity and the nature of its business. In implementing reasonable safeguards, covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients' privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards.

Many health care providers and professionals have long made it a practice to ensure reasonable safeguards for individuals' health information – for instance:

- By speaking quietly when discussing a patient's condition with family members in a waiting room or other public area;
- By avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- By isolating or locking file cabinets or records rooms; or
- By providing additional security, such as passwords, on computers maintaining personal information.

Protection of patient confidentiality is an important practice for many health care and health information management professionals; covered entities can build upon those codes of conduct to develop the reasonable safeguards required by the Privacy Rule.

## May a physician's office or health plan use mail or fax to send patient medical information?

Yes. Where the Privacy Rule allows covered health care providers, health plans, or health care clearinghouses to share protected health information with another organization or with the individual, they may use a variety of means to deliver the information, as long as they use reasonable safeguards when doing so. When the communications are in writing, the patient information may be sent by mail, fax, or other means of reliable delivery.

The Privacy Rule requires that covered entities apply reasonable safeguards when making these communications to protect the patient information from inappropriate use or disclosure to unauthorized persons. These safeguards will vary depending on the mode of communication used. For example, when mailing patient information, reasonable safeguards would include checking to see that the name and address of the recipient are correct and current and that only the minimum amount of patient information is showing on the outside of the envelope to ensure proper delivery to the intended recipient. When faxing protected health information to a telephone number that is not regularly used, a reasonable safeguard would include first confirming the fax number with the intended recipient. Similarly, a covered entity may pre-program frequently used numbers directly into the fax machine to avoid misdirecting the information to someone who is not the intended recipient.

The following checklists provide guidance on reasonable safeguards that a covered health care provider, health plan, or health care clearinghouse may put in place to protect patient information from being impermissibly disclosed during (1) mailing and (2) faxing. See 45 C.F.R. § 164.530(c).

### MAILING CHECKLIST

<input type="checkbox"/>	Carefully check name and address of intended recipient. Many names are similar; make sure you have the correct name for the intended recipient on the envelope. Make sure the address on the envelope matches the correct address of the intended recipient.
<input type="checkbox"/>	Carefully check the contents of the envelope before sealing. Make sure the contents may be permissibly disclosed to the intended recipient or properly relate to the individual. Check all pages to make sure records or material related to other individuals are not mistakenly included in the envelope.
<input type="checkbox"/>	Check the information showing on the outside of the envelope or through the address window. Make sure identifying information that is not necessary to ensure proper delivery is not disclosed.
<input type="checkbox"/>	When doing mass mailings, do a test run to ensure the system is properly performing and check at least a sample of the mailings for the accuracy of name and address of the intended recipients and the correct contents, as indicated above, before sending.
<input type="checkbox"/>	Have policies and procedures in place to safeguard protected health information that is mailed, including processes to act promptly on (1) name and address changes to ensure corrections are made in all the relevant records; and (2) reports of misdirected mail to identify the cause and take steps to prevent future incidents.
<input type="checkbox"/>	Train staff on the mailing procedures that your organization has put in place to safeguard protected health information during mailing. Update the training periodically and be sure to train new staff.

## FAXING CHECKLIST

<input type="checkbox"/>	Carefully check the fax number to make sure you have the correct number for the intended recipient. When manually entering the number, check to see that it has been entered correctly before sending.
<input type="checkbox"/>	Confirm fax number with the intended recipient when faxing to this party for the first time or if the fax number is not regularly used.
<input type="checkbox"/>	Program regularly used numbers into fax machines. Check to make sure you are selecting the preprogrammed number for the correct party before sending.
<input type="checkbox"/>	Update fax numbers promptly upon receipt of notification of correction or change. Have procedures for deleting outdated or unused numbers which are preprogrammed into the fax machine.
<input type="checkbox"/>	Locate fax machines in areas where access can be monitored and controlled and avoid leaving patient information on fax machines after sending.
<input type="checkbox"/>	Have policies and procedures in place to safeguard protected health information that is faxed, including processes to act promptly on (1) changes in fax numbers to ensure corrections are made in all the relevant records; and (2) reports of a misdirected fax to identify the cause and take steps to prevent future incidents, including revising the organization's policies and procedures.
<input type="checkbox"/>	Train staff on the policies and procedures for the proper use of fax machines that your organization has put in place to safeguard protected health information during faxing. Update the training periodically and be sure to train new staff.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
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<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

July 14, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: 17-272773

Dear (b)(6);(b)(7)(C)

On June 7, 2017, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received your complaint alleging that Planned Parenthood of San Rafael, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164, Subparts A and E, the Privacy Rule). Specifically, you allege that on June 6, 2017, Planned Parenthood of San Rafael located at 2 H Street, San Rafael, CA 94901, provided you with the prescription order of another patient, in error. This allegation could reflect a violation of 45 C.F.R. §§ 164.502(a) and 164.530(c).

Thank you for bringing this matter to OCR's attention. Your complaint plays an integral part in OCR's enforcement efforts.

OCR enforces the Privacy, Security, and Breach Notification Rules, and also enforces Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

The Privacy Rule allows health care providers and health plans to share protected health information (PHI) for permitted purposes, as long as they use reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of the PHI. See 45 C.F.R. § 164.502(a). These safeguards may vary depending on the mode of communication used. When providing PHI to individuals in person, a reasonable safeguard may involve both verifying the identity of the individual to whom the PHI is being provided, and ensuring that the PHI provided does not inadvertently include PHI of other individuals.

We have carefully reviewed your complaint against the covered entity and have determined to resolve this matter informally through the provision of technical assistance to the covered entity. Should OCR receive a similar allegation of noncompliance against the covered entity in the future, OCR may initiate a formal investigation of that matter.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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 you have any questions about this matter, please contact Centralized Case Management Operations at (800) 368-1019 or (202) 619-3257 (TDD).

Sincerely,

A handwritten signature in black ink, appearing to read "T. Noonan". The signature is fluid and cursive, with a large initial "T" and a stylized "N".

Timothy Noonan  
Acting Director, CCMO



English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



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



YOUR FIRST NAME: (b)(6);(b)(7)(C)
YOUR LAST NAME: (b)(6);(b)(7)(C)
HOME / CELL PHONE: (b)(6);(b)(7)(C)
WORK PHONE:
STREET ADDRESS: (b)(6);(b)(7)(C)
CITY: (b)(6);(b)(7)(C)
STATE: (b)(6);(b)(7)(C)
ZIP: (b)(6);(b)(7)
E-MAIL ADDRESS: (If available)

Are you filing this complaint for someone else? [ ] Yes [X] 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: Iron Mountain/ Planned Parenthood of Boston
STREET ADDRESS: 1 Federal Street
CITY: Boston
STATE: Massachusetts
ZIP: 02110
PHONE: (Please include area code)

When do you believe that the violation of health information privacy rights occurred?
LIST DATE(S): 07/03/2017

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)
Hi- Today I received a phone call indicating that some of my personal information was disclosed regarding my medical history. Once an address was revealed, immediately I knew where the source of the information came from. So, I thought. I called Planned Parenthood on Commonwealth Ave to see if I can get access to my information and explained to them what happened and was told that because I haven't been a patient in over 10 years, my files are over at Iron Mountain and the person who looked through my files were not at Planned Parenthood that the only time my file was accessed was today. The information is regarding an abortion, someone is sending out messages to people indicating that I recently had an abortion within the last three months. This is not true. I haven't had an abortion since I lived at (b)(6);(b)(7)(C) in (b)(6);(b) and that was the address the person reported, over 10
This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

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: (b)(6);(b)(7)(C)
DATE (mm/dd/yyyy): 07/05/2017

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.

**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 us 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 / CELL 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)
---------------	---------------------------

**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.**

<p align="center"><b>Region I - CT, ME, MA, NH, RI, VT</b></p> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<p align="center"><b>Region V - IL, IN, MI, MN, OH, WI</b></p> 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	<p align="center"><b>Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions</b></p> 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
<p align="center"><b>Region II - NJ, NY, PR, VI</b></p> 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	<p align="center"><b>Region VI - AR, LA, NM, OK, TX</b></p> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<p align="center"><b>Region III - DE, DC, MD, PA, VA, WV</b></p> 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	<p align="center"><b>Region VII - IA, KS, MO, NE</b></p> 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	
<p align="center"><b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b></p> 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	<p align="center"><b>Region VIII - CO, MT, ND, SD, UT, WY</b></p> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<p align="center"><b>Region X - AK, ID, OR, WA</b></p> Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (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 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: 07/05/2017

*\*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)

Hi- Today I recived a phone call indicating that some of my personal information was disclosed regarding my medical history. Once an address was revealed, immedicately I knew where the source of the information came from. So, I thought. I called Planned Parenthood on Commonwealth Ave to see if I can get access to my information and explained to them what happened and was told that because I haven't been a patient in over 10 years, my files are over at Iron Mountain and the person who looked through my files were not at Planned Parenthood that the only time my file was accessed was today. The information is regarding an abortion, someone is sending out messages to people indicating that I recently had an abortion within the last three months. This is not true. I haven't had an abortion since I lived at (b)(6);(b)(7)(C) and that was the address the person reported, over 10 years ago. My issue is that someone who works at Iron mountain had to pull my file in order to get this information. If it came from my health insurance provider, the address would have been a more recent or my current home address. Not only is this a toatl violation of my privacy, it's embarrassing since I'm in a relationship with someone. This incident had to have happened within the last few weeks if not within the last week.

Best regard, (b)(6);(b)(7)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

July 14, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: CU-17-275156

(b)(6);(b)(7)(C)

vs. Iron Mountain/ Planned Parenthood of Boston

Dear (b)(6);(b)(7)(C)

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination, as stated in this letter, applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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.

We regret we are unable to assist you further. Thank you.

Sincerely,

Timothy Noonan  
Acting Director, CCMO

English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE FOR CIVIL RIGHTS (OCR)  
HEALTH INFORMATION PRIVACY COMPLAINT**

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



YOUR FIRST NAME (b)(6);(b)(7)(C)		YOUR LAST NAME (b)(6);(b)(7)(C)	
HOME / CELL PHONE (Please include area code) (b)(6);(b)(7)(C)		WORK PHONE (Please include area code) (b)(6);(b)(7)(C)	
STREET ADDRESS (b)(6);(b)(7)(C)		CITY (b)(6);(b)(7)(C)	
STATE (b)(6);(b)(7)(C)	ZIP (b)(6);(b)(7)(C)	E-MAIL ADDRESS (If available) (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
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**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 Keystone

STREET ADDRESS 5920 Hamilton Blvd		CITY Allentown
STATE Pennsylvania	ZIP 18106	PHONE (Please include area code)

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

LIST DATE(S)

07/07/2017

**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)**

A staff member at our Warminster Medical Center received a call from a patient. The patient explained that she received a follow up letter addressed to another patient. The staff member asked the patient to return the letter to the center as soon as possible. The patient agreed to drop off or mail the letter back to the center.

HIPAA Officer was made aware of the situation on 07/07/2017.

**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 (b)(6);(b)(7)(C)	DATE (mm/dd/yyyy) 07/07/2017
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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 us 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 / CELL 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.**

<p align="center"><b>Region I - CT, ME, MA, NH, RI, VT</b></p> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<p align="center"><b>Region V - IL, IN, MI, MN, OH, WI</b></p> 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	<p align="center"><b>Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions</b></p> 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
<p align="center"><b>Region II - NJ, NY, PR, VI</b></p> 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	<p align="center"><b>Region VI - AR, LA, NM, OK, TX</b></p> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<p align="center"><b>Region III - DE, DC, MD, PA, VA, WV</b></p> 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	<p align="center"><b>Region VII - IA, KS, MO, NE</b></p> 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	
<p align="center"><b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b></p> 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	<p align="center"><b>Region VIII - CO, MT, ND, SD, UT, WY</b></p> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<p align="center"><b>Region X - AK, ID, OR, WA</b></p> Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (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 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: 07/07/2017

*\*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.

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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.

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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)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

July 21, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: CU-17-275396

(b)(6);(b)(7)(C)

vs. Planned Parenthood Keystone

Dear (b)(6);(b)(7)(C)

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination, as stated in this letter, applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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.

We regret we are unable to assist you further. Thank you.

Sincerely,

Timothy Noonan  
Acting Director, CCMO

English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по-русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.



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



YOUR FIRST NAME, YOUR LAST NAME, HOME / CELL PHONE, WORK PHONE, STREET ADDRESS, CITY, STATE, ZIP, E-MAIL ADDRESS

Are you filing this complaint for someone else? 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

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. (b)(6);(b)(7)(C) is my mother. She had an appointment for a Pap test at the Franklinton Planned Parenthood center.

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

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

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.

**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 us 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 / CELL 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)
---------------	---------------------------

**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.**

<p align="center"><b>Region I - CT, ME, MA, NH, RI, VT</b></p> Office for Civil Rights, DHHS JFK Federal Building - Room 1875 Boston, MA 02203 (617) 565-1340; (617) 565-1343 (TDD) (617) 565-3809 FAX	<p align="center"><b>Region V - IL, IN, MI, MN, OH, WI</b></p> 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	<p align="center"><b>Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions</b></p> 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
<p align="center"><b>Region II - NJ, NY, PR, VI</b></p> 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	<p align="center"><b>Region VI - AR, LA, NM, OK, TX</b></p> Office for Civil Rights, DHHS 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX	
<p align="center"><b>Region III - DE, DC, MD, PA, VA, WV</b></p> 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	<p align="center"><b>Region VII - IA, KS, MO, NE</b></p> 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	
<p align="center"><b>Region IV - AL, FL, GA, KY, MS, NC, SC, TN</b></p> 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	<p align="center"><b>Region VIII - CO, MT, ND, SD, UT, WY</b></p> Office for Civil Rights, DHHS 999 18th Street, Suite 417 Denver, CO 80202 (303) 844-2024; (303) 844-3439 (TDD) (303) 844-2025 FAX	<p align="center"><b>Region X - AK, ID, OR, WA</b></p> Office for Civil Rights, DHHS 701 Fifth Avenue, Suite 1600, MS - 11 Seattle, WA 98104 (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 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: 07/12/2017

*\*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)

(b)(6);(b)(7)(C) s my mother. She had an appointment for a Pap test at the Franklinton Planned Parenthood center. I arrived with her and checked in. There were a few other people in the small lobby and she was called a couple of times to answer some administrative questions (e.g. demographic questions). After completing this part, we sat for a while and she was called to the window again - this time, a Health care assistant asked her why she was there and we told her for a pap test. She asked how old she was. My mother answered that she was 68. Then the HCA inquired as to whether there was a particular reason she wanted a pap test. We were at bit surprised because we couldn't understand why the questions was being asked. Or at least, I couldn't.

The HCA kept asking about past tests, how long it had been since the last test and what issues she was having that warranted a visit. My mom and I looked at each other and didn't respond, so the HCA asked whether she was having any discharge, pain, etc. After that last question, we looked at her a bit confused because there were other people in the lobby. My mom answered but I then asked if there was a reason we were being questioned about this personal stuff in the lobby. I said that there was a counter behind the door and these personal questions could be asked there.

The HCA stated she wanted to establish why my mom was coming in for an appointment. She said the guidelines had changed and because of my mom's age, my mom did not need a pap smear. She took out a paper that she read and said that the new policy stated that if you were between the ages of 20 and 60, you needed a pap test every 3 years. However, if you were over 60 you did not need a pap smear. My mom stated that she was just concerned. Being an attorney, I explained that the policy is saying there is no need to but the patient in this case has expressed a need to have a pap smear done. We went back and forth and she rolled her eyes and said that the clinician would determine whether my mother needed the pap test or just a vaginal infection test.

It is not like they were offering this service for free. We were paying for the test. My mother was so upset that her blood pressure shot up to over 200/100. These are stroke levels and thank God, I was able to calm her down after the visit. The clinician had to take her BP again to check where it was.

I asked to speak to the manager of the place. First, they said the manager was the Medical Director and he was not there. I emphasized that there should be an administrative manager. Finally, someone called (b)(6);(b)(7) came. I told her what happened and the HCA came closer to where we were. The HCA folded her hands and looked at me. (b)(6);(b) stated that she did not think the HCA did anything wrong. My mom said she had to sit down because she was so upset and so when I asked for the HCA's name so I could file a complaint, (b)(6);(b) said we were overreacting, put her hand on my shoulder and stated, "Don't

raise your blood pressure as well." I told her she was being patronizing and I would take this matter to their corporate office.

My concern is that for a center funded by and servicing the public, the employees here do not know how to address health information and discussions but also, they do not know when they have violated a policy. This was a small lobby, people were present, they already mentioned my mom's name a few times, and now they were questioning her about her vaginal issues in the lobby.

I would like to officially file a complaint against this facility.





DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019  
TDD - (202) 619-3257  
Fax - (202) 619-3818  
<http://www.hhs.gov/ocr>

Office for Civil Rights  
200 Independence Avenue, S.W.,  
Room 509F  
Washington, DC 20201

July 24, 2017

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: CU-17-275772

(b)(6);(b)(7)(C)

vs. Planned Parenthood

Dear (b)(6);(b)(7)(C):

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination, as stated in this letter, applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event 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.

We regret we are unable to assist you further. Thank you.

Sincerely,

Timothy Noonan  
Acting Director, CCMO

English	If you speak a non-English language, call 1-800-368-1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文, 请拨打1-800-368-1019 (打字电话: 1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.