Ontario County

HEALTH INFORMATION PRIVACY COMPLAINT FORM

YOUR FIRST NAME	YOUR 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)

Are you filing this complaint for someone else? Yes / No	If yes, whose health information rights do you believe were violated? FIRST NAME LAST NAME

Who or what County Department do you believe violated your (or someone else's) health information rights?

On what date(s) do you believe the violation occurred?	Describe briefly how and why you believe your (or someone else's) health information rights were violated.

Do you need special accommodations to communicate with you regarding this complaint?

- ☐ Braille
- ☐ Sign Language interpreter (specify language) ______________________________
- ☐ Foreign language interpreter (specify language) ____________________________
- ☐ Large Print
- ☐ Electronic mail
- ☐ Other ____

SIGNATURE	DATE