

OFFICE OF THE ATTORNEY GENERAL  
STATE OF CONNECTICUT

HEALTH INFORMATION PRIVACY COMPLAINT

Name \_\_\_\_\_

Telephone \_\_\_\_\_

Address \_\_\_\_\_

Email address (optional) \_\_\_\_\_

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, Security, or Breach Notification Rule.

Person/Agency/Organization \_\_\_\_\_

Address \_\_\_\_\_

When do you believe that the violation of health information privacy/security/breach notification rights occurred? \_\_\_\_\_

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy/security/breach notification rights were violated. Please be specific as possible (attach additional pages as needed) \_\_\_\_\_

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

Filing a complaint with the Office of the Attorney General (OAG) is voluntary. However, without the information requested above, the OAG may be unable to proceed with your complaint. We collect this information under the authority of the Health Insurance Portability and Accountability Act of 1996 as amended. 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 to the extent provided under federal and state law. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy/security/breach notification violations, for internal systems operations, or for routine uses, which include disclosure of information outside the OAG for purposes associated with health information privacy compliance and/or as required by law. It is illegal for a covered entity or business associate to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under HIPAA. To submit a complaint, please send it to:

**Office of the Attorney General, 165 Capitol Ave, Hartford, CT 06106**

COMPLAINANT CONSENT FORM

Name of complainant: \_\_\_\_\_

I, the complainant named above, understand, and authorize the State of Connecticut Office of the Attorney General (OAG) to:

- collect and receive materials and information about my complaint, including personal and medical records which are relevant to its investigation.
- Reveal my identity or identifying information about me to person(s) at the entity or agency under investigation or to other persons, agencies, or entities during any part of OAG's investigation or enforcement process.

\_\_\_\_\_

Date

Complainant