WHISTLEBLOWER COMPLAINT FORM

File Number: ___________________

Staff of the Department of Health Care Services (DHCS) or DHCS business associates may report a suspected violation of the HIPAA Privacy Rule by another employee or a violation of DHCS' privacy policies and procedures. DHCS will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual or business associate for filing a complaint. The information you provide here will remain confidential to the extent possible. DHCS may need to share the information to investigate your complaint. You may submit your complaint to either the DHCS or to the U.S. Department of Health and Human Services (DHHS) as follows:

MAIL THIS COMPLETED COMPLAINT FORM TO: PRIVACY OFFICER C/O OFFICE OF LEGAL SERVICES DEPARTMENT OF HEALTH CARE SERVICES P.O. BOX 997413, MS 0010 SACRAMENTO, CA 95899-7413	YOU MAY FILE A COMPLAINT WITH THE SECRETARY OF DHHS TO: SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES U.S. OFFICE FOR CIVIL RIGHTS 50 UNITED NATIONS PLAZA, ROOM 322 SAN FRANCISCO, CA 94102

YOUR INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:
BEST WAY TO REACH YOU:	BEST HOURS TO REACH YOU:	
WHISTLEBLOWERS MAY FILE COMPLAINTS ANONYMOUSLY	DIVISION/BRANCH:	SUPERVISOR'S NAME:

CONSENT TO DISCLOSE YOUR NAME

PLEASE SELECT ONE OF THE FOLLOWING:

☐ I CONSENT TO MY NAME BEING DISCLOSED TO INVESTIGATE THIS COMPLAINT.

☐ I DO NOT CONSENT TO MY NAME BEING DISCLOSED. PLEASE NOTE THAT NOT USING YOUR NAME MAY HINDER OUR ABILITY TO COMPLETE THE INVESTIGATION.

INFORMATION ABOUT YOUR COMPLAINT		
NAME OF THE ORGANIZATION YOUR COMPLAINT IS AGAINST:	NAME OF PERSON YOUR COMPLAINT IS AGAINST:	DATE(S) ACTION(S) OCCURRED:
PLEASE PROVIDE A DETAILED DESCRIPTION OF YOUR COMPLAINT COVERING *WHAT, WHEN, WHO, HOW, WHERE,* AND *WHY.* YOU MAY ATTACH ADDITIONAL PAGES IF THERE IS NOT ENOUGH SPACE HERE.		
DO YOU HAVE WITNESS(ES)? ☐ YES ☐ NO IF YES, PLEASE PROVIDE THE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF YOUR WITNESSES BELOW:		
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )

RESOLUTION OF YOUR COMPLAINT
PLEASE DESCRIBE HOW YOU BELIEVE THAT YOUR PRIVACY COMPLAINT COULD BE RESOLVED:

YOUR SIGNATURE	
I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF. SIGNATURE:	DATE: