RAYMOND W. BLISS ARMY HEALTH CENTER

HEALTH INFORMATION PRIVACY COMPLAINT

The purpose of this form is to provide the patient or their personal representative with a means to report concerns or suspected privacy violations of Protected Health Information (PHI).

If you have any questions regarding this form, call the RWBAHC HIPAA Privacy Officer at:
(520) 533-1856 or (520) 533-3194

Filing a complaint with the Raymond W. Bliss Army Health Center (RWBAHC) is voluntary. However, without the information requested, RWBAHC may be unable to proceed with your complaint. 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 information outside the Military Health System/TRICARE 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 HIPAA Privacy Rule.

Name (Last, First, MI):	Date of Birth (YYYYMMDD):	Patient DOD ID or Last four of patient/ sponsor SSN:

Home Phone:	Work Phone:
Cell Phone:	Email Address:
Street Address:	

City:	State:	Zip Code:

1. Are you filing a complaint on behalf of another individual? Yes ☐ No ☐
   If yes, please provide the following information:

Name of Individual (Last, First, Middle Initial):	Date of Birth (YYYYMMDD):	Title/Rank:

2. Where did the violation occur? *Note: The violation must have originated at a healthcare facility under the Military Health System (i.e. Military Treatment Facility)*

Facility Name:	Clinic/Department if Known:

Street Address:	City:	State:	Zip Code:

3. Please provide the name(s) of the individual(s) you believe caused the violation.
Note: The alleged violator(s) must be a workforce member of the Military Health System, including contractors and business associates.

Name: (Last, First, Middle Initial):	Title/Rank:

4. When did the violation occur? If exact date(s) is unknown, provide approximate timeframe.

5. When were you made aware of the violation?

6. What type of HIPAA violation occurred? Select all that are applicable:

☐ Unauthorized access/viewing of health information
☐ Unauthorized disclosure of health information
☐ Loss of health information records
☐ Retaliation for filing a previous complaint
☐ Failure to receive requested health records or accounting of disclosures
☐ Other (Explain: _____)

7. In the space below, please summarize the HIPAA violation(s) you believe occurred and if necessary attach any relevant details on the alleged incident:

8. Are you aware of any other individual(s) who may be able to provide further information regarding the allegations? Yes ☐ No ☐

If yes, please provide the following information:

Name of Individual:	Phone Number:
Name of Individual:	Phone Number:
Name of Individual:	Phone Number:

Signature of Patient/Guardian:	Relationship to Patient (*If applicable*)	Date:

Notice: You may print this form and mail it to:
Raymond W. Bliss Army Health Center
ATTN: HIPAA Privacy Office
2240 East Winrow Ave.
Fort Huachuca, AZ 85613-7079