

**Rhode Island Department of Human Services
Health Information Privacy Complaint**

**For assistance, call (401) 462-2130 (Voice)
TDD(hearing impaired) 711 or (401) 462-6239**

Your First Name	Your Last Name
Home Phone ()	Work Phone ()
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 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	
Street Address	City, State, ZIP
Phone ()	

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

List Date(s)

Have you filed your complaint anywhere else? If so, please provide the following.

Person/ Agency/ Organization/ Court Name(s)	
Date(s) Filed	Case Number(s) (if known)

