Note: I did accidentally pay the invoice sent to me by Quest Diagnostics; and after a month or so and a couple requests via phone, they reimbursed me for my unnecessary payment. (Account statement copies included)

Enclosed please find these related documents:

1. HHS-700 Privacy Complaint 2 pgs
2. Complainant Consent Form 2 pgs
3. Quest Diagnostics laboratory invoice # (b)(6);(b)(7)(C) dated March 24, 2015
4. "Billing Services" form from Quest Diagnostics internet website
5. Copy of reimbursement check to me from Quest Diagnostics
6. Quest Diagnostics lab results "Report Status: Partial"
7. Planned Parenthood of SW and Central FL labs results
8. Pg 6 of Planned Parenthood HIPPA notice
9. Planned Parenthood "Encounter Invoice" (b)(6);(b)(7)(C)
10. Planned Parenthood "Prompt Pay Discount" form 2 pgs
11. Planned Parenthood "Request for Medical Services & Acknowledgement of Receipt of Health Information Privacy Practice Notice" 2 pgs

Quest Diagnostics

Do not use address below:
P.O. Box 7306
Hollister, MO 65673-7306

# Laboratory Invoice

For services not included in your physician's bill

| Invoice Date: | Amount Due: | Due Date: |
|---|---|---|
| Mar. 24, 2015 | (b)(6);(b)(7)(C) | Apr. 14, 2015 |

**Invoice Number** (b)(6);(b)(7)(C)
**Lab Code** TAM

(b)(6);(b)(7)(C)

Patient Name: (b)(6);(b)(7)(C)
Responsible Party:
Date of Service: October 21, 2014

Lab Results and Diagnosis Questions Must Be Answered By Your Physician.

**Customer Service**
LOG ON NOW at www.QuestDiagnostics.com/bill to conveniently pay your invoice, provide updated insurance information, or take a patient survey.

**Pay by Phone:** 1-855-584-6850 (24 hours/7 days)
**Questions:** 1-800-488-8890
Mon - Thurs 8AM - 6PM EST & Friday 8AM -5 PM EST
Se Habla Espanol

***Please have your invoice available for reference.***

## Laboratory Tests Were Requested By:

Referring Physician:
Physician Address: (b)(6);(b)(7)(C)

## Most Recent Insurance Claim Filed To:

Insurance Name:
Insurance ID:
Group Number:

**This invoice is for laboratory tests performed at the request of the referring physician. These charges are separate from the physician's fees. We were unable to bill your insurance carrier due to missing information on the original test order. Please contact us at your earliest convenience to provide your complete insurance information. Thank you for using our laboratory.**

| Date | CPT Code * | Test Description | Charge | Insurance Discount | Insurance Paid | Medicare/ Medicaid Paid | Patient Paid | Patient Owes |
|---|---|---|---|---|---|---|---|---|
| 10/21/14 | 86780 | AB, TREPONEMA PALLIDUM | (b)(6);(b)(7)(C) | | | | | |
| 10/21/14 | 86592 | RPR (DX) W/REFL TITE | | | | | | |
| 10/21/14 | 86593 | SEROLOGY;QT | | | | | | |

**Tax ID: 38-2084239 ICD-9 Codes: V74.5**

Services Performed by: QUEST DIAGNOSTICS TAMPA TAMPA, FL

* The CPT codes provided are for information purposes only, and are based on AMA guidelines without regard to specific payer requirements

091247 1/1

Rec'd
3-27-15

Gmail by Google

Jeanie Glass (b)(6);(b)(7)(C)

**quest labs**
1 message

(b)(6);(b)(7)(C)

Fri, Apr 24, 2015 at 12:41 PM

# Billing Services

## Check Invoice Status

### Invoice Status/Insurance Information

| | |
|---|---|
| **Invoice Number** | 3194608475 |
| **Insurance Company Billed** | BIP NON PAR PATIENT REBIL |
| **Insurance Company Address** | DO NOT MAIL CLAIMS<br>DO NOT MAIL CLAIM XX 99999 |
| **Amount Billed** | (b)(6);(b)(7) |
| **Billed Date** | 03/21/2015 |
| **Insurance Response Date** | |
| **Insurance Payment/Adjustments Amount** | (b)(6);(b)(7)(C) |
| **Insurance Response** | Patient Payment |
| **Bill To Name** | (b)(6);(b)(7)(C) |
| **Patient Payment Amount** | (b)(6);(b)(7)(C) |
| **Last Payment Date** | 04/06/2015 |
| **Patient's Responsibility** | $0.00 |

DR8926

7,78

Quest Diagnostics Incorporated
PO Box 5001
Collegeville, PA 19426-0901

0014137661

Page 1 of 1

Quest Diagnostics

Address Service Requested

(b)(6);(b)(7)(C)

Check Date: 05/01/2015
Vendor Number: (b)(4)

| Invoice Number | Invoice Date | Voucher Number | Group | Reference | Gross Amount | Discount Amount | Net Amount |
|---|---|---|---|---|---|---|---|
| (b)(6);(b)(7)(C | 04/28/15 | (b)(6);(b)(7 | | QUESTIONS? PLEASE CALL 1 -800-488-8890 | (b)(4) | | |
| | | | | | (b)(6);(b)(7)(C) | | |

SHADED AREA MUST GRADUALLY CHANGE FROM BLUE AT TOP TO GREEN AT BOTTOM

(b)(6);(b)(7)(C)

Quest Diagnostics Incorporated
PO Box 5001
Collegeville, PA 19426-0901

66-156/531

Quest Diagnostics

Net Amount
USD

Pay Exactly ******169* Dollars and * 80 * Cents

Date
05/01/2015

(b)(6);(b)(7)(C)

TO THE ORDER OF

(b)(6);(b)(7)(C)

(b)(6);(b)(7)(C)
Authorized Signer

(b)(6);(b)(7)(C)
Authorized Signer

WELLS FARGO BANK, N.A.

VOID IF NOT CASHED IN 180 DAYS

emancipated, minors who are donating blood or tissue samples and minors who are independently seeking examination and treatment for a sexually transmissible disease. It is important to note that when making such an independent health care decision, only the minor can authorize the use and disclosure of the minor's health information with respect to the independent health care decision. Moreover, the minor holds all of the rights listed in this Notice related to the protection of health information concerning such an independent health care decision. However, if the minor elects to inform the parent or guardian and obtain parental or guardian consent for the independent health care decision, then all of the privacy rights regarding the health information for the independent health care decision may revert back to the parent or guardian.

There are also certain situations where adults other than the parent or guardian can access, use and/or disclose a minor's health information without the consent of the parent or guardian. These situations usually occur where the law recognizes that the health or safety of the minor is in danger and access to or use and disclosure of health information without appropriate authorization is necessary to appropriately protect the minor. Such situations include minors who are suffering from emergency medical conditions, minors who have independently sought contraceptive information and services, and minors who are victims of child abuse, abandonment or neglect.

Abortions for Minors. We may, under some circumstances, be required by law to give notice to the parents of minors who intend to utilize our abortions services. Please feel free to seek further information from your physician.

## CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facility and on our website. The Notice contains the effective date on the first page.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact: "The Privacy Official at Planned Parenthood of Southwest and Central Florida". All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

## USES OF HEALTH INFORMATION REQUIRING AN AUTHORIZATION

The following uses and disclosures of health information will be made only with your written permission:

- Uses and disclosures of protected health information for marketing purposes
- Use and disclosures that constitute the sale of your protected health information
- Other uses and disclosures of health information not covered by this Notice or the laws that apply to us.

If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.

| IF PAYING BY CREDIT CARD, FILL OUT BELOW | | |
|---|---|---|
| CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA | | |
| CARD NUMBER | CVV | AMOUNT |
| SIGNATURE | | EXP. DATE |
| STATEMENT DATE | PAY THIS AMOUNT | ACCOUNT NBR |
| 04/04/15 | $0.00 | (b)(6);(b)(7)(C) |
| TAX ID NUMBER (b)(6);(b)(7)(C) | SHOW AMOUNT PAID HERE $ | |

# ENCOUNTER INVOICE (b)(6);(b)(7)(C)

ADDRESSEE:
(b)(6);(b)(7)(C)

REMIT TO:

**Planned Parenthood Of SW and Central FL**
736 Central Ave
Sarasota, FL 34236-4042

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

| DATE | PATIENT NAME | PROVIDER | CPT4 | DIAG | DESCRIPTION OF SERVICE | AMOUNT |
|---|---|---|---|---|---|---|
| 10/21/14 | (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) | 87491 | V74.5 | CHYLMD TRACH, DNA, AMP PROBE | (b)(6);(b)(7)(C) |
| 10/21/14 | | | 87591 | V74.5 | N.GONORRHOEAE, DNA, AMP PROB | |
| 10/21/14 | | | 8670392-92 | V74.5 | RAPID HIV | |
| 10/21/14 | | | 99203 | V74.5 | DETAILED, NEW, 30 | |
| 10/21/14 | | | 36415 | V74.5 | ROUTINE VENIPUNCTURE | |
| 10/21/14 | | | 36416 | V74.5 | CAPILLARY BLOOD DRAW | |
| 10/21/14 | | | 86592 | V74.5 | RPR | |
| 10/21/14 | | | EBCM2 | V74.5 | Condoms | |
| 10/21/14 | | | DONATION | V74.5 | DONATION (QTY 3) | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | .Patient Payment Cash | |
| 10/21/14 | | | | | Prompt Pay Discount | |
| 10/21/14 | | | | | Prompt Pay Discount | |
| 10/21/14 | | | | | Prompt Pay Discount | |
| 10/21/14 | | | | | Prompt Pay Discount | |
| 10/21/14 | | | | | Prompt Pay Discount | |
| 10/21/14 | | | | | Prompt Pay Discount | |

| ACCOUNT NBR | CHARGES | PAYMENTS | REFUNDS/ ADJUSTMENTS | ESTIMATED BALANCE DUE FROM INSURANCE | BALANCE DUE FROM PATIENT |
|---|---|---|---|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) | | | | |

**MESSAGE:**
This receipt represents charges for today's visit only, any prior charges or balances may still be owed.

| PLEASE PAY THIS AMOUNT »»»»» | $0.00 |
|---|---|

** PAYMENT DUE UPON RECEIPT * THANK YOU **

**ENCOUNTER INVOICE**

Printed by betzaida.staff (78) on 4/4/2015 12:33:16 PM

Planned Parenthood®
Care. No matter what.
Planned Parenthood of Southwest & Central Florida, Inc.

PATIENT: (b)(6);(b)(7)(C)
DOB: (b)(6);(b)(7)(C)
MRN: (b)(6);(b)(7)(
DATE: 10/21/2014 01:24 PM

# Prompt Pay Discount

**To Our Patients with No Insurance:** All charges are due and payable in full at time of service. We offer a prompt pay discount for all services paid at the time of service and are not billable to a third party payer. We accept most major credit cards, debit cards (with a Visa or Mastercard logo), and/or cash.

**Acknowledgment**: By accepting a prompt pay discount at the time of service, I hereby acknowledge that I will pay my bill in full at the time of service and that I will not be submitting a receipt to a third party payer for reimbursement for any of the services provided herein. I further understand that Planned Parenthood of Southwest Central Florida reserves the right to revoke the prompt pay discount if I do not pay in full at the time of service, in which, the full, non-discounted rates will be applied to the unpaid services; and/or if I submit a receipt to a third party payer, in which, the full, non-discounted rates will be applied and a new claim will be submitted to the carrier for proper processing. In such case, I understand I will be liable for the patient responsibility assignment per my insurance benefits.

**Release of Information**: The physician(s)/clinician(s) may disclose all or part of the patient's record to any person or corporation which is, or may be, liable under a contract to the physician(s)/clinician(s) or the patient or to the family member or employer of the patient for all or part of the physician(s)/clinician(s) charges, including but not limited to, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

**By signing below, I understand the information provided to me herein and I acknowledge all of my questions have been answered satisfactorily.**

Client Signature:

(b)(6);(b)(7)(C)

Signed By: (b)(6);(b)(7)(C)

I witness that the client received this information, said she read and understood it, and had an opportunity to ask questions.

Witness Signature:
(b)(6);(b)(7)(C)

Signed By: (b)(6);(b)(7)(C)

Rev 6/20/14

Encounter location recorded at:
Sarasota HC
736 Central Avenue
Sarasota, FL 34236-4042
Proprietary and Confidential
Version 4.4.3.4 EHR (5.8/8.1)

Planned Parenthood®
Care. No matter what.
Planned Parenthood of Southwest & Central Florida, Inc.

PATIENT: (b)(6);(b)(7)(C)
DATE OF BIRTH: (b)(6);(b)(7)(C)
MEDICAL RECORD: (b)(6);(b)(7)(C)
DATE: 10/21/2014 01:24 PM

# Request For Medical Services
# &
# Acknowledgment of Receipt of Health Information Privacy Practice Notice (HIPAA)

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

**I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.**

I understand that, in the event of an abnormal test result, I will be contacted by telephone and/or mail at the address and telephone numbers I provided.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I will be told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Southwest Central Florida's *Notice of Health Information Privacy Practices* and I consent to the use and disclosure of my health information as described in the *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

***Please note that Planned Parenthood of Southwest and Central Florida is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.***

**I hereby acknowledge** receipt of Planned Parenthood of Southwest Central Florida's notice of health information privacy practices.

Client Signature:

(b)(6);(b)(7)(C)

Signed By: (b)(6);(b)(7)(C)

I witness that the client received this information, said she read and understood it, and had an opportunity to ask questions.

Witness Signature:

(b)(6);(b)(7)(C)

Signed By: (b)(6);(b)(7)(C)

Rev 5/20/14

Encounter location recorded at:
Sarasota HC
736 Central Avenue
Sarasota, FL 34236-4042

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (404) 562-7886, (800) 368-1019
TDD - (404) 562-7884, (800) 537-7697
Fax - (404) 562-7881
http://www.hhs.gov/ocr

Office for Civil Rights, Region IV
Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303

AUG 19 2015

(b)(6);(b)(7)(C)

OCR Transaction Number: 04-15-214268

Dear (b)(6);(b)(7)(C)

On June 25, 2015, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), Region IV received your complaint alleging that Planned Parenthood of Southwest and Central Florida, Inc. violated the Federal Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164, Subparts A and E, the Privacy Rule) and the Breach Notification Rule Subpart D - Notification in Case of Breach of Unsecured Protected Health Information ("PHI") (45 C.F.R. §§ 164.400-164.414)."

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter. OCR's determination as stated in this applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

We regret we are unable to assist you further.

Sincerely,

Timothy Noonan
Regional Manager
Office for Civil Rights

| | |
|---|---|
| English | If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost. |
| Español - Spanish | Si usted habla español marque 1800 368-1019 ( o a la línea de teléfono por texto TTY 1800-537-7697 ) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno. |
| 中文 - Chinese | 如果你讲中文，请拨打 1-800-368-1019 （打字电话：1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务 |
| Tiếng Việt - Vietnamese | Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí. |
| 한국어 - Korean | 한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다. |
| Tagalog (Filipino) | Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-369-1019 (TTY:1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad. |
| Русский - Russian | Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно. |

Form Approved: OMB No. 0935-0143 See OMB Statement on page 2.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights (OCR)

# PATIENT SAFETY CONFIDENTIALITY COMPLAINT

| | |
|---|---|
| Your First Name: (b)(6);(b)(7)(C) | Your Last Name: (b)(6);(b)(7)(C) |
| Home Phone *(Please include area code)*: (b)(6);(b)(7)(C) | Work Phone *(Please include area code)*: (b)(6);(b)(7)(C) |
| Street Address: (b)(6);(b)(7)(C) | City: (b)(6);(b)(7)(C) |
| State: (b)(6);(b)(7)(C) ZIP: (b)(6);(b)(7)(C) | E-Mail Address *(If available)*: (b)(6);(b)(7)(C) |

**Who is the patient, provider or reporter who is identified in the information you believe was impermissibly disclosed?**

| | |
|---|---|
| First Name or Business Name: PLANNED PARENTHOOD | Last Name *(Leave blank if using Business Name to left)* |

**Who (e.g., provider, patient safety organization, other person) do you believe disclosed patient safety work product in violation of patient safety confidentiality?**

RECEIVED
FEB 13 2015
HHS/OCR/HQ

| | | |
|---|---|---|
| Person/Agency/Organization: PLANNED PARENTHOOD FEDERATION OF AMERICA | | |
| Street Address: 1110 VERMONT AVE NW. SUITE 300 | City: WASHINGTON | |
| State: DC | ZIP: 20005 | Phone: (202) 973-4800 |

**When do you believe that the impermissible disclosure occurred?**
List Date(s): FEBRUARY - MARCH 2011

**Describe briefly what happened. How and why do you believe a person or organization impermissibly disclosed patient safety work product? Please be as specific as possible. Why do you believe the information disclosed is patient safety work product?** ***(Attach additional pages as needed)***

I REQUESTED AN APPOINTMENT FOR PLANNED PARENTHOOD MULTIPLE TIMES WITH NO RESPONSE. I THEN RECEIVED A CALL FROM MY PARTNER AT THE TIME STATING I HAD COME IN CONTACT WITH SOMEONE ELSE. HE HAD BEEN INFORMED OF THIS VIA A FRIEND OF HIS CALLING HIM. WE SHARED NO SORT OF COMMUNICATION DEVICES OR ADDRESS. FALSE INFORMATION WAS DISCLOSED WITHOUT MY CONSENT AND CAUSED IRREPARABLE DAMAGE.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| | | |
|---|---|---|
| Signature: (b)(6);(b)(7)(C) | | Date *(mm/dd/yyyy)*: 2/5/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act). We use it to investigate your complaint to see whether enforcement action is appropriate. The Privacy Act of 1974 protects the information submitted on this form. We may share your information with the Department of Justice or a court in the event of a lawsuit, with another agency that has jurisdiction over potential violations or reviews certifications of Patient Safety Organizations, or with others who help us carry out our work. Otherwise, OCR will not share your name or other identifying information about you unless you agree. You are not required to use this form. You may write a letter or submit a complaint electronically with the same information. You will find directions for submitting an electronic complaint on our web site at *http://hhs.gov/ocr/privacy/psa/complaint/index.html*. To mail a complaint see reverse page for OCR address.


PSC Graphics (301) 443-1090 EF

***The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.***

**Do you need special accommodations for us to communicate with you about this complaint? *(Check all that apply)***

☐ Braille ☐ Large print ☐ Cassette tape ☐ Computer diskette ☒ Electronic Mail ☐ TDD

☐ Sign language interpreter *(Specify language)*: _____

☐ Foreign language interpreter *(Specify language)*: _____

☐ Other *(Specify)*: _____

***To help us better serve you, answer the following question.***

HOW DID YOU LEARN ABOUT THE OFFICE FOR CIVIL RIGHTS?

☒ HHS Website / Internet Search ☐ Family / Friend / Associate ☐ Religious / Community Org ☒ Lawyer / Legal Org

☐ Phone Directory ☐ Employer ☒ Fed / State / Local Gov ☒ Healthcare Provider / Health Plan

☐ Conference / OCR Brochure ☐ Other *(Specify)*: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| First Name | Last Name | |
|---|---|---|
| Home Phone *(Please include area code)* | Work Phone *(Please include area code)* | |
| Street Address | | City |
| State | ZIP | E-Mail Address *(If available)* |

**Have you filed your complaint anywhere else? If so, please provide the following: *(Attach additional pages as needed)***

| Person / Agency / Organization / Court Name(s) | |
|---|---|
| Date(s) Filed | Case Number(s) *(If known)* |

## *To mail a complaint, please type or print, and return completed complaint to:*

Office for Civil Rights
Department of Health and Human Services
Attn: Patient Safety Act
200 Independence Ave., SW, Rm. 509F
Washington, DC 20201
(202) 619-0403
TDD 1-800-537-7697
FAX: (202) 619-3818

To submit an electronic complaint, see our web site at *http://hhs.gov/ocr/privacy/psa/complaint/index.html*.

### Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 20 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201.

**Subject:** There is an important message waiting for you from Planned Parenthood Mar Monte

**From:** patientservices@medfusion.net (patientservices@medfusion.net)

**To:** (b)(6);(b)(7)(C)

**Date:** Saturday, February 19, 2011 11:55 PM

# Planned Parenthood Mar Monte

Dear (b)(6);(b)(7)(C):

Planned Parenthood Mar Monte has sent you a secure communication. Because we value our confidential relationship with you, this message is only available to be viewed through our secure online patient portal. To access the portal and view this communication, please go to

(b)(4)

1. Click on My Patient Page

2. Enter your User ID and password in the left column under Login.

3. Go to "My Messages"

If you have forgotten your login, you will find a link for "Forgot My Password" and "Forgot My User ID" on all the login pages of the patient portal.

This secure online patient portal is a great way for you to receive timely health information, manage your own healthcare, and stay in touch with your physicians without having to spend costly time on the phone or in the waiting room.

We look forward to continuing to serve you with this convenient, secure means of communication.

Regards,

Planned Parenthood Mar Monte Staff

**Please note: Do not respond to this email. Log on to our site to securely communicate with us.**

**Subject:** Fw: Privacy/Confidentiality/Disclosure to Outside Parties

**From:** (b)(6);(b)(7)(C)

**To:** (b)(6);(b)(7)(C)

**Date:** Wednesday, March 2, 2011 4:54 PM

----- Forwarded Message ----
**From:** (b)(6);(b)(7)(C)
**To:** (b)(6);(b)(7)(C)
**Sent:** Wed, March 2, 2011 9:52:32 AM
**Subject:** Privacy/Confidentiality/Disclosure to Outside Parties

Planned Parenthood ,

First off let me say forgive me for any spelling or writing errors.I have not slept for three days.I am writing this lette year ,I was diagnosed with genital HPV.I was told that it was not a matter of worry as it 'goes away on its own' and that with all but disappeared.I also embarked on a relationship in July 2, 2010 that has now deteriorated recently due to events surrou

I have,forgive me, *had* a partner in Oakland who was in no way associated with Planned Parenthood,let alone my a understanding that it is my right to have confidentiality unless proven to be detrimental or life threatening to parties involve thing.My primary concern at the time was to have my HPV checked on post Gardisil and make inquiries regarding ways of e someone affiliated with Planned Parenthood on the morning of February 27,2011 informing that I had an STD test scheduled make them aware of any business or doings within Planned Parenthood.Long and short of it, I had no 'U.P. Sex with New Pa normally.

I am not condoning my actions in deceiving you with my reason(s) for priority.However,I am holding whoever cont someone that may or may not know my partner in a formal setting,but I believe does know them well enough to know that I t things like this happen and how issues of privacy and confidentiality are shared within Planned Parenthood.I am not seekin

Please feel free to contact me with any information or insight into this matter as soon as possible.My cell phone nu the Planned Parenthood website in hopes that I may expedite the process.Please contact me as soon as possible with any in

**Subject:** Re: Follow-up to your Letter dated 3/2/2011

**From:** (b)(6);(b)(7)(C)

**To:**

**Date:** Monday, August 4, 2014 7:05 PM

It's been about 3 years since our initial contact email.I am still having trouble and looking for closure.Would you like to talk?

On Friday, March 11, 2011 4:35 PM, (b)(6);(b)(7)(C) wrote:

Dear (b)(6);

Your letter was forwarded to me by our California Office located in Sacramento. Can you help us help you by telling me which Planned Parenthood you visited and which one called your former partner? I also want to add that your experience does not sound like anything we at PPMM support and my apologies for your loss.

Best,

(b)(6);(b)(7) RN, BS, MBA
Chief Operating Officer
Planned Parenthood Marmonte
1691 The Alameda
San Jose, CA 95126
(408) 795-3610 Direct
(408) 287-0405 Fax

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Protecting Personal Information in Complaint Investigations* and *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

☒ **CONSENT**: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☐ **CONSENT DENIED**: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 2/5/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please type or print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this fact sheet, please contact OCR
http://www.hhs.gov/ocr/contact.html

*OR*

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Office of the Secretary

Voice - (800) 368-1019
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue, S.W.,
Room 509F
Washington, DC 20201

July 17, 2015

(b)(6);(b)(7)(C)

RE: OCR Transaction Number: 15-215833
(b)(6);(b)(7)(C) vs Planned Parenthood Federation of America

Dear (b)(6);(b)(7)(C)

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces Federal civil rights laws that prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and, under certain circumstances, sex and religion. OCR also has jurisdiction over health plans, health care clearinghouses, and certain health care providers with respect to enforcement of the Privacy, Security, and Breach Notification Rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under our regulations, OCR normally can only accept complaints that are filed within 180 days of an alleged act of discrimination or privacy violation. Your complaint against Planned Parenthood Federation of America alleges an act that occurred February through March of 2011, which is more than 180 days before you filed your complaint, February 13, 2015. The information you provided is not sufficient to extend the 180 day deadline for filing. As such, we regret to inform you that the Office for Civil Rights cannot accept your complaint for investigation.

We regret that we are unable to assist you in this matter. If you any have questions about this matter, please contact Centralized Case Management Operations at (800) 368-1019.

Sincerely,

Sarah C. Brown
Interim Associate Deputy Director for Regional Operations

Free language assistance services are provided by OCR to conduct OCR related matters only.

| | |
|---|---|
| English | If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost. |
| Español - Spanish | Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno. |
| 中文 - Chinese | 如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697），你将被连接到一位讲同语种的翻译员为你提供免费服务。 |
| Tiếng Việt - Vietnamese | Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí. |
| 한국어 - Korean | 한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다. |
| Tagalog (Filipino) | Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad. |
| Русский - Russian | Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно. |

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OFFICE FOR CIVIL RIGHTS (OCR)

# HEALTH INFORMATION PRIVACY COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| (b)(6);(b)(7 | (b)(6);(b)( |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| | (b)(6);(b)(7)(C) |

| STREET ADDRESS | CITY |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |

| STATE | ZIP | E-MAIL ADDRESS (If available) |
|---|---|---|
| (b)(6);(b)( | (b)(6);(b)(7) | (b)(6);(b)(7)(C) |

**Are you filing this complaint for someone else?** [X] Yes [ ] No

If Yes, whose health information privacy rights do you believe were violated?

| FIRST NAME | LAST NAME |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |

**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

Planned Parenthood

| STREET ADDRESS | CITY |
|---|---|
| 290 Northland blv | Cincinnati |

| STATE | ZIP | PHONE (Please include area code) |
|---|---|---|
| Ohio | 45246 | |

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

LIST DATE(S)

06/29/2015

**Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible.** (Attach additional pages as needed)

On 06/29/2015 (b)(6);(b)(7)(C) health information was told to me by the nurse of planned parenthood . They ask me what was his reason for me coming in my response was my girlfriend (b)(6);(b)(7)(C) came and the doctor told her to tell me to be seen and the nurse response was "okay well let me pull up her chart and check and see what On here " he said "okay" the nurse then replied "oh your fine her test results came bavk she was negative for everything the only thing that came back was BV but would you still like to get tested " his reply was "yes that's fine " I they took everything to get tested.

Later on that night we were together and I her ask if She had called up there or heard anything she said no and then I told her that she was fine because they said you have BV every thing else is

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| (b)(6);(b)(7)(C) | 08/06/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. 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 possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department 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 Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at:
**www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☒ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | 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) | |

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☒ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☒ HHS Website/Internet Search ☒ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

**To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.**

**Region I - CT, ME, MA, NH, RI, VT**
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

**Region II - NJ, NY, PR, VI**
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3312
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

**Region III - DE, DC, MD, PA, VA, WV**
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

**Region IV - AL, FL, GA, KY, MS, NC, SC, TN**
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 16T70
Atlanta, GA 30303-8909
(404) 562-7886; (404) 562-7884 (TDD)
(404) 562-7881 FAX

**Region V - IL, IN, MI, MN, OH, WI**
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

**Region VI - AR, LA, NM, OK, TX**
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

**Region VII - IA, KS, MO, NE**
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

**Region VIII - CO, MT, ND, SD, UT, WY**
Office for Civil Rights, DHHS
999 18th Street, Suite 417
Denver, CO 80202
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

**Region X - AK, ID, OR, WA**
Office for Civil Rights, DHHS
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

# COMPLAINANT CONSENT FORM

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Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

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- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 08/06/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

## CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

On 06/29/2015 (b)(6);(b)(7)(C) health information was told to me by the nurse of planned parenthood . They ask me what was his reason for me coming in my response was my girlfriend (b)(6);(b)(7)(C) came and the doctor told her to tell me to be seen and the nurse response was "okay well let me pull up her chart and check and see what On here " he said "okay" the nurse then replied "oh your fine her test results came bavk she was negative for everything the only thing that came back was BV but would you still like to get tested " his reply was "yes that's fine " I they took everything to get tested.

Later on that night we were together and I her ask if She had called up there or heard anything she said no and then I told her that she was fine because they said you have BV every thing else is neagative. She called 06/30/2015 and they said the exact same things that I was told by the nurse on duty that she had BV.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Office of the Secretary

Voice - (800) 368-1019
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue, S.W.,
Room 509F
Washington, DC 20201

(b)(6);(b)(7)(C)

RE: OCR Transaction Number: CU-15-217333
(b)(6);(b)(7)(C) vs Planned Parenthood

Dear (b)(6);(b)(7)(C):

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint against Planned Parenthood and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination as stated in this applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

We regret we are unable to assist you further. Thank you.

Sincerely yours,

Sarah C. Brown
Interim Associate Deputy Director
for Regional Operations

| | |
|---|---|
| English | If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost. |
| Español - Spanish | Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno. |
| 中文 - Chinese | 如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。 |
| Tiếng Việt - Vietnamese | Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí. |
| 한국어 - Korean | 한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다. |
| Tagalog (Filipino) | Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad. |
| Русский - Russian | Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно. |

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

# HEALTH INFORMATION PRIVACY COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| (b)(6);(b)( | (b)(6);(b)(7)(C) |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| (b)(6);(b)(7)(C) | |

| STREET ADDRESS | CITY |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |

| STATE | ZIP | E-MAIL ADDRESS (If available) |
|---|---|---|
| (b)(6);(b) | (b)(6);(b)(7) | (b)(6);(b)(7)(C) |

**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 |
|---|---|
| | |

**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

Planned Parenthood

| STREET ADDRESS | CITY |
|---|---|
| 290. Northland Blvd | Cincinnati |

| STATE | ZIP | PHONE (Please include area code) |
|---|---|---|
| Ohio | 45246 | (513) 772-2207 |

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

LIST DATE(S)

**Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible.** (Attach additional pages as needed)

On 06/29/2015 my health information was violated by the Planned Parenthood location in Springdale ohio by the nurse who look to be a Mexican female to my boyfriend (b)(6);(b)(7)(C) during his doctor visit. I had an appointment on 06 /25 /2015 where I went to get a checked up. During my check up the doctor said tha during my check up the doctor said that things were not looking too good i had sta to her that I had BV she disagreed and said no I don't believe so this looks like something else so I'm going to treat you for everything just in case tell your boyfriend that he needs to be checked as well because you do not want the same thing to occur once you have been treated. I was given the medicine and because of its high dosage I experience nausea headache and fatigue i was not able to attend class due to these conditions. I was sent home and said that my test results from the samples

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| (b)(6);(b)(7)(C) | 08/07/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. 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 possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department 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 Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at:
**www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☒ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | 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) |
|---|---|---|

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☒ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☒ HHS Website/Internet Search ☒ Family/Friend/Associate ☐ Religious/Community Org ☒ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

**To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.**

**Region I - CT, ME, MA, NH, RI, VT**
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

**Region II - NJ, NY, PR, VI**
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3312
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

**Region III - DE, DC, MD, PA, VA, WV**
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

**Region IV - AL, FL, GA, KY, MS, NC, SC, TN**
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 16T70
Atlanta, GA 30303-8909
(404) 562-7886; (404) 562-7884 (TDD)
(404) 562-7881 FAX

**Region V - IL, IN, MI, MN, OH, WI**
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

**Region VI - AR, LA, NM, OK, TX**
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

**Region VII - IA, KS, MO, NE**
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

**Region VIII - CO, MT, ND, SD, UT, WY**
Office for Civil Rights, DHHS
999 18th Street, Suite 417
Denver, CO 80202
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

**Region X - AK, ID, OR, WA**
Office for Civil Rights, DHHS
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 08/07/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

## CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

On 06/29/2015 my health information was violated by the Planned Parenthood location in Springdale ohio by the nurse who look to be a Mexican female to my boyfriend (b)(6);(b)(7)(C) during his doctor visit. I had an appointment on 06 /25 /2015 where I went to get a checked up. During my check up the doctor said tha during my check up the doctor said that things were not looking too good i had sta to her that I had BV she disagreed and said no I don't believe so this looks like something else so I'm going to treat you for everything just in case tell your boyfriend that he needs to be checked as well because you do not want the same thing to occur once you have been treated. I was given the medicine and because of its high dosage I experience nausea headache and fatigue i was not able to attend class due to these conditions. I was sent home and said that my test results from the samples that were taken we're going to be reported to me within 2 weeks but the call just in case I called every day and I was told that results have not been in yet. On 06/29/2015 my boyfriend asked if I had spoken to the doctor to get my test results back I said no and then that's when he told me that he went to the clinic and they said it was no reason for him to get the medication because by the looking at my chart the only thing that came up positive was BV. I was very embrassed and puzzled by the fact of him knowingsomething so personal and having to explain what BV was. This is something i never would have thought would happen to me. I also contacted my instructor to see what action to take.

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OFFICE FOR CIVIL RIGHTS (OCR)

# CIVIL RIGHTS DISCRIMINATION COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| (b)(6);(b)(7)(C) | |
| STREET ADDRESS | CITY |
| (b)(6);(b)(7)(C) | (b)(6);(b) |
| STATE | ZIP |
| (b)(6);(b)(7)(C) | (b)(6);(b)(7) |

E-MAIL ADDRESS (If available): (b)(6);(b)(7)(C)

**Are you filing this complaint for someone else?** ☐ Yes ☒ No

If Yes, whose civil rights do you believe were violated?

| FIRST NAME | LAST NAME |
|---|---|
| | |

**I believe that I have been (or someone else has been) discriminated against on the basis of:**

☐ Race / Color / National Origin ☐ Age ☐ Religion ☐ Sex

☐ Disability ☒ Other (specify): my rights were breeched

**Who or what agency or organization do you believe discriminated against you (or someone else)?**

PERSON/AGENCY/ORGANIZATION

planned parent hood

| STREET ADDRESS | CITY |
|---|---|
| 1040 state st | schenctady |
| STATE | ZIP |
| New York | 12307 |

PHONE (Please include area code):

**When do you believe that the civil right discrimination occurred?**

LIST DATE(S)

04/23/2015

**Describe briefly what happened. How and why do you believe that you have been (or someone else has been) discriminated against? Please be as specific as possible.** (Attach additional pages as needed)

I was seen at planned parent hood on
April 23rd 2015 for a personal procedure, and its been bought to my attention that someone who works there by the name of (b)(6);(b)(7)(C) who resides at (b)(6);(b)(7)(C) is telling my personal information about the business that I had done at that planned parent hood facility

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| (b)(6);(b)(7)(C) | 08/18/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of1973 and other civil rights statutes. 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 possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | 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) | |

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

**To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.**

**Region I - CT, ME, MA, NH, RI, VT**
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

**Region II - NJ, NY, PR, VI**
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3312
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

**Region III - DE, DC, MD, PA, VA, WV**
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
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**Region IV - AL, FL, GA, KY, MS, NC, SC, TN**
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 16T70
Atlanta, GA 30303-8909
(404) 562-7886; (404) 562-7884 (TDD)
(404) 562-7881 FAX

**Region V - IL, IN, MI, MN, OH, WI**
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

**Region VI - AR, LA, NM, OK, TX**
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

**Region VII - IA, KS, MO, NE**
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

**Region VIII - CO, MT, ND, SD, UT, WY**
Office for Civil Rights, DHHS
999 18th Street, Suite 417
Denver, CO 80202
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

**Region X - AK, ID, OR, WA**
Office for Civil Rights, DHHS
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 08/18/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

## CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Office of the Secretary

Voice - (800) 368-1019
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue, S.W.,
Room 509F
Washington, DC 20201

July 20, 2017

(b)(6);(b)(7)(C)

RE: OCR Transaction Number: CU-15-218055
(b)(6);(b)(7)(C) vs Planned Parenthood

Dear (b)(6);(b)(7)(C)

Thank you for your correspondence to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint against Planned Parenthood and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination as stated in this applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

We regret we are unable to assist you further. Thank you.

Sincerely yours,

Sarah C. Brown
Interim Associate Deputy Director
for Regional Operations

| | |
|---|---|
| English | If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost. |
| Español - Spanish | Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno. |
| 中文 - Chinese | 如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。 |
| Tiếng Việt - Vietnamese | Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí. |
| 한국어 - Korean | 한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다. |
| Tagalog (Filipino) | Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad. |
| Русский - Russian | Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно. |

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OFFICE FOR CIVIL RIGHTS (OCR)

# HEALTH INFORMATION PRIVACY COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| (b)(6);(b)(7)(C) | |

| STREET ADDRESS | CITY |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |

| STATE | ZIP | E-MAIL ADDRESS (If available) |
|---|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |

**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 |
|---|---|
| | |

**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

Planned Parenthood Mar Monte

| STREET ADDRESS | CITY |
|---|---|
| 5440 Thornwood Dr , Suite G | San Jose |

| STATE | ZIP | PHONE (Please include area code) |
|---|---|---|
| California | 95123 | (408) 281-9777 |

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

LIST DATE(S)

08/17/2015, 08/21/2015, 08/22/2015

**Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible.** (Attach additional pages as needed)

I am filing for negligence in providing confidential communications by Planned Parenthood Mar Monte. During a recent visit on 8/17/15, when asked to verify my information I noticed that my mailing address on file was my residential address and my out of state address, that I had previously listed as mailing address, was listed as my residential address. Upon noticing the error, I immediately told the receptionist that I would like to receive all communications at my out of state address and under no circumstances am I to receive anything at my local residential address. She assured me the error would be changed

On August 24, I received a letter from the clinic at my local address, that I had requested not to be

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| (b)(6);(b)(7)(C) | 08/25/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. 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 possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department 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 Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at:
**www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | 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) | |

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☒ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☐ HHS Website/Internet Search ☒ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

**To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.**

**Region I - CT, ME, MA, NH, RI, VT**
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

**Region II - NJ, NY, PR, VI**
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3312
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

**Region III - DE, DC, MD, PA, VA, WV**
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

**Region IV - AL, FL, GA, KY, MS, NC, SC, TN**
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 16T70
Atlanta, GA 30303-8909
(404) 562-7886; (404) 562-7884 (TDD)
(404) 562-7881 FAX

**Region V - IL, IN, MI, MN, OH, WI**
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

**Region VI - AR, LA, NM, OK, TX**
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

**Region VII - IA, KS, MO, NE**
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

**Region VIII - CO, MT, ND, SD, UT, WY**
Office for Civil Rights, DHHS
999 18th Street, Suite 417
Denver, CO 80202
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

**Region X - AK, ID, OR, WA**
Office for Civil Rights, DHHS
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

☐ **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

☒ **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 08/25/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

## CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

I am filing for negligence in providing confidential communications by Planned Parenthood Mar Monte. During a recent visit on 8/17/15, when asked to verify my information I noticed that my mailing address on file was my residential address and my out of state address, that I had previously listed as mailing address,  was listed as my residential address. Upon noticing the error, I immediately told the receptionist that I would like to receive all communications at my out of state address and under no circumstances am I to receive anything at my local residential address. She assured me the error would be changed

On August 24, I received a letter from the clinic at my local address, that I had requested not to be my mailing address. The letter contained very sensitive information, that had I not been the one to open it first, would have resulted in very dire consequences. The letter was written on August 21 and postmarked August 22, both dates much later than the date of my initial request for confidential communications.

I immediately called their phone number, however, it was directed to the Mar Monte branch calling center instead of the actual clinic, and I was told that my request would be "sent to the clinic, and I was to hear back from them in 48 hours." Not only do I have no way of verifying that my address would be corrected this time, I believe that 48 hours is not a timely manner considering that I have no idea when they may mail another sensitive letter.

The clinic has neglected to provide confidential communications, even after promising to do so.

**DEPARTMENT OF HEALTH & HUMAN SERVICES** **OFFICE OF THE SECRETARY**

Voice - (415) 437-8310, (800) 368-1019
TDD - (415) 437-8311, (800) 537-7697
(FAX) - (415) 437-8329
http://www.hhs.gov/ocr/

**Office for Civil Rights, Pacific Region**
**90 7th Street, Suite 4-100**
**San Francisco, California 94103**

December 18, 2015

(b)(6);(b)(7)(C)

Re: OCR Transaction Number: 15-218563

Dear (b)(6);(b)(7)(C)

On August 25, 2015, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received your complaint alleging that Planned Parenthood Mar Monte, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules). Specifically, you allege that, on August 17, 2015, you discovered at a recent visit that your residential address was on the file folder rather than your mailing address. You requested a correction at that time and followed up with a phone call that went to the main office rather than the clinic where you discovered the error. Several days after your request, you received sensitive information at the incorrect address, despite your instructions and follow up phone call. This allegation could reflect a violation of 45 C.F.R. §§ 164.530(c).

Thank you for bringing this matter to OCR's attention. Your complaint is an integral part of OCR's enforcement efforts.

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of PHI in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. 45 C.F.R. §164.530(c). For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes.

We have carefully reviewed your complaint against Planned Parenthood Mar Monte and have determined to resolve this matter informally through the provision of technical assistance to Planned Parenthood Mar Monte. Should OCR receive a similar allegation of noncompliance

against Planned Parenthood Mar Monte in the future, OCR may initiate a formal investigation of that matter.

For your informational purposes, OCR has enclosed material regarding the Privacy Rule provisions related to Safeguards.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If you have any questions regarding this matter, please contact our office at (415) 437-8310 or (800) 368-1019.

Sincerely,

Michael Leoz
Regional Manager

Enclosure: Reasonable Safeguards

**Reasonable Safeguards**

45 C.F.R. § 164.530 (c)

A covered entity must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures. See 45 C.F.R. §164.530 (c). It is not expected that a covered entity's safeguards guarantee the privacy of protected health information from any and all potential risks. Reasonable safeguards will vary from covered entity to covered entity depending on factors, such as the size of the covered entity and the nature of its business. In implementing reasonable safeguards, covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients' privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards.

Many health care providers and professionals have long made it a practice to ensure reasonable safeguards for individuals' health information – for instance:

- By speaking quietly when discussing a patient's condition with family members in a waiting room or other public area;
- By avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- By isolating or locking file cabinets or records rooms; or
- By providing additional security, such as passwords, on computers maintaining personal information.

Protection of patient confidentiality is an important practice for many health care and health information management professionals; covered entities can build upon those codes of conduct to develop the reasonable safeguards required by the Privacy Rule.

**DEPARTMENT OF HEALTH & HUMAN SERVICES** **OFFICE OF THE SECRETARY**

Voice - (415) 437-8310, (800) 368-1019
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http://www.hhs.gov/ocr/

**Office for Civil Rights, Pacific Region**
**90 7th Street, Suite 4-100**
**San Francisco, California 94103**

December 18, 2015

Planned Parenthood Mar Monte
Privacy Officer
5440 Thornwood Drive, Suite G
San Jose, CA 95123

Re: OCR Transaction Number: 15-218563

Dear Privacy Officer:

On August 25, 2015, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received a complaint alleging that Planned Parenthood Mar Monte, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules). Specifically, the complainant alleges that, on August 17, 2015, a patient discovered at a recent visit that her residential address was on the file folder rather than her mailing address. She requested a correction at that time and followed up with a phone call that went to the main office rather than the clinic where she discovered the error. Several days after her request, she received sensitive information at the incorrect address, despite her instructions and follow up phone call. This allegation could reflect a violation of 45 C.F.R. §§ 164.530(c).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

In this matter, the complainant alleges that the covered entity does not employ reasonable safeguards to prevent impermissible disclosures of protected health information (PHI). A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of PHI in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. 45 C.F.R. §164.530(c).

Pursuant to its authority under 45 C.F.R. §§ 160.304(a) and (b), OCR has determined to resolve this matter informally through the provision of technical assistance to Planned Parenthood Mar Monte. To that end, OCR has enclosed material explaining the Privacy Rule provisions related to Reasonable Safeguards.

You are encouraged to review these materials closely and to share them with your staff as part of the Health Insurance Portability and Accountability Act (HIPAA) training you provide to your workforce. You are also encouraged to assess and determine whether there may have been any

noncompliance as alleged by the complainant in this matter, and, if so, to take the steps necessary to ensure such noncompliance does not occur in the future. In addition, OCR encourages you to review the facts of this individual's complaint and provide the individual the appropriate written response swiftly if necessary to comply with the requirements of the Privacy Rule. Should OCR receive a similar allegation of noncompliance against Planned Parenthood Mar Monte in the future, OCR may initiate a formal investigation of that matter. In addition, please note that, after a period of six months has passed, OCR may initiate and conduct a compliance review of Planned Parenthood Mar Monte related to your compliance with the Privacy Rule's provisions related to Reasonable Safeguards.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If you have any questions regarding this matter, please contact our office at (415) 437-8310 or (800) 368-1019.

Sincerely,

Michael Leoz
Regional Manager

Enclosure: Reasonable Safeguards

**Reasonable Safeguards**

45 C.F.R. § 164.530 (c)

A covered entity must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures. See 45 C.F.R. §164.530 (c). It is not expected that a covered entity's safeguards guarantee the privacy of protected health information from any and all potential risks. Reasonable safeguards will vary from covered entity to covered entity depending on factors, such as the size of the covered entity and the nature of its business. In implementing reasonable safeguards, covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients' privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards.

Many health care providers and professionals have long made it a practice to ensure reasonable safeguards for individuals' health information – for instance:

- By speaking quietly when discussing a patient's condition with family members in a waiting room or other public area;
- By avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- By isolating or locking file cabinets or records rooms; or
- By providing additional security, such as passwords, on computers maintaining personal information.

Protection of patient confidentiality is an important practice for many health care and health information management professionals; covered entities can build upon those codes of conduct to develop the reasonable safeguards required by the Privacy Rule.

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OFFICE FOR CIVIL RIGHTS (OCR)

# HEALTH INFORMATION PRIVACY COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| (b)(6);(b)(7)( | (b)(6);(b) |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| (b)(6);(b)(7)(C) | |
| STREET ADDRESS | CITY |
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |
| STATE | ZIP |
| (b)(6);(b)(7)(C) | (b)(6);(b)(7) |

E-MAIL ADDRESS (If available): (b)(6);(b)(7)(C)

**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 |
|---|---|
| | |

**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

Planned Parenthood

| STREET ADDRESS | CITY |
|---|---|
| 6353 North Broadway | Chicago |
| **STATE** | **ZIP** |
| Illinois | 60660 |

PHONE (Please include area code): (773) 973-3393

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

LIST DATE(S)

09/03/2015

**Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible.** (Attach additional pages as needed)

I arrived at the Planned Parenthood of Rogers Park at 10:45am to obtain a refill for my birth control. I waited for about 15 minutes and went up to the front desk to ask about the status of my refill. Two girls were behind the front desk reviewing my file, when one of them, in a waiting room with other patrons, announced that I didn't have a current prescription for my birth control and that during my last visit I was prescribed ********. She announced what i was prescribed and the nature of my conditions into a crowded waiting room, when that information is private and personal. The waiting room is audio and video recorded so this can be proven easily. I was furious so I then left.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| (b)(6);(b)(7)(C) | 09/05/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. 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 possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department 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 Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at: **www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | 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) |
|---|---|---|

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☒ Other (specify): Searched Online for

**To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.**

**Region I - CT, ME, MA, NH, RI, VT**
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

**Region II - NJ, NY, PR, VI**
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3312
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

**Region III - DE, DC, MD, PA, VA, WV**
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

**Region IV - AL, FL, GA, KY, MS, NC, SC, TN**
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 16T70
Atlanta, GA 30303-8909
(404) 562-7886; (404) 562-7884 (TDD)
(404) 562-7881 FAX

**Region V - IL, IN, MI, MN, OH, WI**
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

**Region VI - AR, LA, NM, OK, TX**
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

**Region VII - IA, KS, MO, NE**
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

**Region VIII - CO, MT, ND, SD, UT, WY**
Office for Civil Rights, DHHS
999 18th Street, Suite 417
Denver, CO 80202
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

**Region X - AK, ID, OR, WA**
Office for Civil Rights, DHHS
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 09/05/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
(v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. §1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

## CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

I arrived at the Planned Parenthood of Rogers Park at 10:45am to obtain a refill for my birth control. I waited for about 15 minutes and went up to the front desk to ask about the status of my refill. Two girls were behind the front desk reviewing my file, when one of them, in a waiting room with other patrons, announced that I didn't have a current prescription for my birth control and that during my last visit I was prescribed ********. She announced what i was prescribed and the nature of my conditions into a crowded waiting room, when that information is private and personal.

The waiting room is audio and video recorded so this can be proven easily. I was furious so I then left.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Voice - (800) 368-1019
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue, S.W.,
Room 509F
Washington, DC 20201

January 7, 2016

(b)(6);(b)(7)(C)

RE: OCR Transaction Number: 15-219430

Dear (b)(6);(b)(7)(C)

On September 5, 2015, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received your complaint alleging that Planned Parenthood, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination as stated in this applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

We regret we are unable to assist you further. Thank you.

Sincerely,

Sarah C. Brown
Interim Associate Deputy Director for Regional Operations

| | |
|---|---|
| English | If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost. |
| Español - Spanish | Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno. |
| 中文 - Chinese | 如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697），你将被连接到一位讲同语种的翻译员为你提供免费服务。 |
| Tiếng Việt - Vietnamese | Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí. |
| 한국어 - Korean | 한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다. |
| Tagalog (Filipino) | Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad. |
| Русский - Russian | Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно. |

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OFFICE FOR CIVIL RIGHTS (OCR)

# HEALTH INFORMATION PRIVACY COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)( |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| (b)(6);(b)(7)(C) | |

| STREET ADDRESS | CITY |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |

| STATE | ZIP | E-MAIL ADDRESS (If available) |
|---|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7 | (b)(6);(b)(7)(C) |

**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 |
|---|---|
| | |

**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

Independence Health Center Planned Parenthood

| STREET ADDRESS | CITY |
|---|---|
| 815 N Noland Road Suite #6 | Independence |

| STATE | ZIP | PHONE (Please include area code) |
|---|---|---|
| Missouri | 64131 | (816) 252-3800 |

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

LIST DATE(S)

09/29/2015

**Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible.** (Attach additional pages as needed)

I went to this facility to do have a Gonorrhea/Chlamydia and Syphilis test done. I instructed the Front Desk, the young woman who first came in to the exam room and spoke with me and the nurse who administered the Ghonorrhea/Chlamydia test that I was NOT authorizing an HIV test. When I went to reception after I was done they even took the charge for the HIV test off because I did not want one at that time. I recieved a phone call from the Johnson County Health Department a week later telling me they had an HIV test result. A test I did not consent to and I repeatedly refused. This agency still drew blood and submitted it for a test that was I did not consent to.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| (b)(6);(b)(7)(C) | 10/12/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. 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 possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department 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 Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at:
**www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | 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) | |

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☒ Other (specify): Web

**To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.**

**Region I - CT, ME, MA, NH, RI, VT**
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

**Region II - NJ, NY, PR, VI**
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3312
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

**Region III - DE, DC, MD, PA, VA, WV**
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

**Region IV - AL, FL, GA, KY, MS, NC, SC, TN**
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 16T70
Atlanta, GA 30303-8909
(404) 562-7886; (404) 562-7884 (TDD)
(404) 562-7881 FAX

**Region V - IL, IN, MI, MN, OH, WI**
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

**Region VI - AR, LA, NM, OK, TX**
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

**Region VII - IA, KS, MO, NE**
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

**Region VIII - CO, MT, ND, SD, UT, WY**
Office for Civil Rights, DHHS
999 18th Street, Suite 417
Denver, CO 80202
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

**Region X - AK, ID, OR, WA**
Office for Civil Rights, DHHS
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

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- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 10/12/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number (b)(6);(b)(7)(C)

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(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
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(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
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OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.

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(i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
(ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
(iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
(iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. §552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. §5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

**Freedom of Information Act**

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. §552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

**Fraud and False Statements**

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".

# PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

## HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

## CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

## CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.

## CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort,

as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

**DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?**

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed $100.00.

If you have any questions about this complaint and consent package,
Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

Contact your OCR Regional Office
(see Regional Office contact information on page 2 of the Complaint Form)

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Office of the Secretary

Voice - (202) 619-0403
TDD - (202) 619-3257
Fax - (202) 619-3818
http://www.hhs.gov/ocr

Office for Civil Rights
200 Independence Avenue,
S.W., Room 506F
Washington, DC 20201

February 11, 2016

(b)(6);(b)(7)(C)

Our Transaction Number: CU-16-222079

Dear (b)(6);(b)(7)(C):

On October 12, 2015, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), received your complaint alleging that Independence Health Center Planned Parenthood, the covered entity, has violated the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules).

OCR enforces the Privacy, Security, and Breach Notification Rules, and also Federal civil rights laws which prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and under certain circumstances, sex and religion.

We have reviewed your complaint and have determined that OCR will not investigate your allegations. Therefore, OCR is closing this complaint with no further action, effective the date of this letter.

OCR's determination as stated in this applies only to the allegations in this complaint that were reviewed by OCR.

Under the Freedom of Information Act, we may be required to release this letter and other information about this case upon request by the public. In the event OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

We regret we are unable to assist you further. Thank you.

Sincerely yours,

Sarah C. Brown
Associate Deputy Director for Regional Operations

| | |
|---|---|
| English | If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost. |
| Español - Spanish | Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno. |
| 中文 - Chinese | 如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697），你将被连接到一位讲同语种的翻译员为你提供免费服务。 |
| Tiếng Việt - Vietnamese | Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí. |
| 한국어 - Korean | 한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다. |
| Tagalog (Filipino) | Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad. |
| Русский - Russian | Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно. |

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

OFFICE FOR CIVIL RIGHTS (OCR)

# HEALTH INFORMATION PRIVACY COMPLAINT

| YOUR FIRST NAME | YOUR LAST NAME |
|---|---|
| (b)(6);(b)( | (b)(6);(b |
| HOME / CELL PHONE (Please include area code) | WORK PHONE (Please include area code) |
| (b)(6);(b)(7)(C) | |

| STREET ADDRESS | CITY |
|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) |

| STATE | ZIP | E-MAIL ADDRESS (If available) |
|---|---|---|
| (b)(6);(b)(7)(C) | (b)(6);(b)(7)(C) | |

**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 |
|---|---|
| | |

**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

all office staff at Planned Parenthood

| STREET ADDRESS | CITY |
|---|---|
| 1235 s Gilbert rd #20 | Mesa |

| STATE | ZIP | PHONE (Please include area code) |
|---|---|---|
| Arizona | 85204 | (602) 277-7526 |

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

LIST DATE(S)

10/22/2015

**Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible.** (Attach additional pages as needed)

The way the office is set up it makes it so you can hear every word being said behind the counter. Staff was loud and unproffessional and made no effort to lower their voices when speaking to us or the other patient even when the topics were very private and quite embarrassing for some. I heard what medications people were prescribed, which std's patients were being checked for, how everyone was ensured, patients were asked very sensitive questions loudly and expected to answer in full earshot of a full waiting room. After several very loud comments I made about the lack of any privacy and several other patients agreeing, they finally turned on a small television. But I don't believe they would have if I hadn't complained continually. I was not happy to have my daughter's private medical choices heard by a full room full of strangers. Staff has NO REGARD for patient privacy here

This field may be truncated due to size limit. See the "Allegation Description" file in the case folder.

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.**

| SIGNATURE | DATE *(mm/dd/yyyy)* |
|---|---|
| (b)(6);(b)(7)(C) | 10/22/2015 |

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. 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 possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department 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 Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's Web site at:
**www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

**The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.**

**Do you need special accommodations for us to communicate with you about this complaint?** (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

**If we cannot reach you directly, is there someone we can contact to help us reach you?**

| FIRST NAME | 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) |
|---|---|---|

**Have you filed your complaint anywhere else? If so, please provide the following.** (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

| DATE(S) FILED | CASE NUMBER(S) (If known) |
|---|---|

**To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).**

ETHNICITY (select one)

☒ Hispanic or Latino

☐ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☒ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

**How did you learn about the Office for Civil Rights?**

☒ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☐ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

**To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.**

**Region I - CT, ME, MA, NH, RI, VT**
Office for Civil Rights, DHHS
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

**Region II - NJ, NY, PR, VI**
Office for Civil Rights, DHHS
26 Federal Plaza - Suite 3312
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

**Region III - DE, DC, MD, PA, VA, WV**
Office for Civil Rights, DHHS
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

**Region IV - AL, FL, GA, KY, MS, NC, SC, TN**
Office for Civil Rights, DHHS
61 Forsyth Street, SW. - Suite 16T70
Atlanta, GA 30303-8909
(404) 562-7886; (404) 562-7884 (TDD)
(404) 562-7881 FAX

**Region V - IL, IN, MI, MN, OH, WI**
Office for Civil Rights, DHHS
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

**Region VI - AR, LA, NM, OK, TX**
Office for Civil Rights, DHHS
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

**Region VII - IA, KS, MO, NE**
Office for Civil Rights, DHHS
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7277; (816) 426-7065 (TDD)
(816) 426-3686 FAX

**Region VIII - CO, MT, ND, SD, UT, WY**
Office for Civil Rights, DHHS
999 18th Street, Suite 417
Denver, CO 80202
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

**Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions**
Office for Civil Rights, DHHS
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

**Region X - AK, ID, OR, WA**
Office for Civil Rights, DHHS
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

**Burden Statement**

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**

# COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

**In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.**

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

**After reading the above information, please check ONLY ONE of the following boxes:**

[X] **CONSENT:** I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

[ ] **CONSENT DENIED:** I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: (b)(6);(b)(7)(C) Date: 10/22/2015

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Please print): (b)(6);(b)(7)(C)

Address: (b)(6);(b)(7)(C)

Telephone Number: (b)(6);(b)(7)(C)

# NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

**Privacy Act**

The Privacy Act of 1974 (5 U.S.C. §552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:
(i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. §1681 et seq.), and Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§295m and 296g);
(ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§291 et seq. and 300s et seq.) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill-Burton facilities);
(iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
(iv) Title II of the Americans with Disabilities Act (42 U.S.C. §12131 et seq.) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS "designated agency" authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
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OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

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Please contact OCR at http://www.hhs.gov/ocr/office/about/contactus/index.html

*OR*

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