Case Number _____

South Carolina Department of Health and Human Services
Office for Civil Rights (OCR)
CIVIL RIGHTS DISCRIMINATION COMPLAINT

If you have questions about this form, call SCDHHS at (803)898-2605. Return the completed form to:
Office for Civil Rights, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206

Your First Name		Your Last Name	
Home Phone		Work Phone	
Street Address			City
State	Zip	Email Address (if available)	

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** ☐ **Disability** ☐ **Age** ☐ **Religion** ☐ **Sex** ☐ **Other: (specify).**_____

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

Person/ Agency/ Organization

Street Address			City
State	Zip	Phone ( )	

When do you believe that the civil rights discrimination 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)

Please Sign and date this complaint	
Signature	**Date**

Filing a complaint with SCDHHS is voluntary. However, without the information requested above, SCDHHS may be unable to proceed with your complaint. We collect this information under the authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 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. You are not required to use this form. You may also write a letter that includes all infomation requested on this form.