Case Number _____

South Carolina Department of Health and Human Services
Office for Civil Rights (OCR)
HEALTH INFORMATION PRIVACY 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 health information privacy rights do you believe were violated?

First Name	Last Name

Who do you believe violated your (or someone else's) health information privacy rights or commited another violation of the HIPAA Privacy Rule?

Person/ Agency/ Organization

Street Address	City

State	Zip	Phone ( )

When do you believe that the violation of health information privacy rights occurred? List Date(s)

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.