STATE OF DELAWARE

COMPLAINT FORM REGARDING HANDLING OF PROTECTED HEALTH INFORMATION

This Form is used by individuals to register complaints concerning the handling of their protected health information ("PHI") in the possession of the health care plans sponsored or maintained by State of Delaware and any of its affiliates, or the business associates of such plans. ***Submit this Completed Form to the Statewide Benefits Office (SBO) by secure email (benefits@state.de.us), fax (302-739-8339) or mail (97 Commerce Way, Suite 201, Dover, DE 19904).*** *Federal law prohibits State of Delaware, its affiliates, and business associates from retaliating against you for filing this complaint.*

COMPLAINANT:
(Print name, addresses, telephone number and date)

Name:
Mailing Address:
Email Address:
Telephone number: Date:

NATURE OF COMPLAINT:

Please describe your complaint. Please be as specific as you can with respect to the details, including names of persons involved (if known), dates, locations, and specific actions or omissions. Write on the back of this sheet, or attach additional sheets, if necessary.

For office use only:

***Receipt*:**
Date: _____ Recipient name: _____ Date delivered to Privacy Official/ Deputy: _____

Investigation:
The Privacy Official or his or her designee must investigate this complaint. The investigation should be documented, and its conclusions reduced to writing. Where warranted, the Privacy Official should direct appropriate remedial action, and impose appropriate sanctions.

Report to Complainant:
The results of the investigation (whether the complaint should prove unfounded or accurate) should be communicated to the complainant (sanctions against persons or other entities need not be revealed).

Complainant notified: *(insert date)*: _____

Privacy Official/Deputy Privacy Official certification: *Initial here:* _____ Date*:* _____

Keep a copy of this Form