How Do I File a Health Information Privacy Complaint?

Before completing this form, please read the attached Information Paper. Further questions may be directed to your local Military Treatment Facility (MTF) Privacy Officer.

Filing a complaint with TRICARE Management Activity (TMA) is voluntary. However, without the information requested TMA may be unable to proceed with your complaint. 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 information outside the Military Health System/TRICARE 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 HIPAA Privacy Rule.

-Instructions-

If you are filing a complaint on your own behalf, complete Sections A and C. If you are filing a complaint on behalf of someone else, complete Sections A, B, & C. Provide your information in Section A and information on the person whose rights may have been violated in Section B.

- Section A -

Last Name	First Name	Middle Initial	Suffix

Work Phone	Home Phone	Email Address	

Street Address	City	State	Zip Code

Social Security Number/FMP	MTF Routinely Accessed for Care

- Section B -

Last Name	First Name	Middle Initial	Suffix

Work Phone	Home Phone	Email Address	

Street Address	City	State	Zip Code

Relationship to Patient

- Section C -

What MTF or other treatment facility do you believe violated your (or someone else's) health information privacy rights or committed another violation of the HIPAA Privacy Rule? **Name of Military Treatment Facility and or Facility location:**

City	State	Zip Code

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

Describe 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 if needed.

SIGNATURE_____ **DATE:**_____

The remaining information on this form is optional. Failure to answer these questions will not affect DoD'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 ☐ Electronic Mail ☐ TTY ☐ Other

☐ Sign Language (specify language)_____

☐ Foreign Language Interpreter (specify language)_____

If we cannot reach you directly, is there someone we can contact to help us reach you? Please put alternate point of contact (POC) information below:

Last Name	First Name	Middle Initial	Suffix
Work Phone	Home Phone	Email Address	
Street Address	City	State	Zip Code

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