

CHESTER AMBULANCE SERVICE

PO Box 370
556 Elm Street
Chester, VT 05143

Health Information Privacy Complaint Form

Your Name: _____ Home Phone: _____

Your Address: _____

City: _____ State: _____ Zip: _____

Who do you believe violated your (or someone else's) health information privacy rights?

Name: _____ Date of violation: _____

Was the violation against you? Yes ___ No ___

If no, whose health information was violated?

Name: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Describe the suspected violation as specific as possible. (Attach additional pages as needed)

Signature: _____ Date: _____

Send this form to our Privacy Officer at the address above. An investigation will be conducted and if found to be true, disciplinary action will ensue. Disciplinary actions will include either suspension or termination and may also result in revocation of any certifications. If you feel that this is not enough, you have the right to file your complaint directly to the U.S. Department of Health and Human Services. For more information contact them at: Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building – Room 1875, Boston MA, 02203 or visit their web site at <http://www.hhs.gov>

