NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Albany, NY 12239

ADMINISTRATIVE SERVICES DIVISION

Health Insurance Portability and Accountability Act Privacy Complaint Form

ADM-302 (9/2023 L)

You have the right to file a complaint with the Department of Civil Service's Complaint Officer about the Department's privacy practices or the Department's compliance with its Privacy Practices Notices, privacy policies and procedures, or federal or State privacy rules or laws, including HIPAA. The Department's Complaint Officer will investigate your complaint and provide you with a written response. You will not be required to waive any right you may have under federal or State law to file your complaint, nor will filing your complaint adversely affect your enrollment in NYSHIP or your use of the Employee Health Service. To file a complaint, please complete, sign and date this form, then mail to:

DCS Complaint Officer
NYS Department of Civil Service
Office of Internal Audit
Albany, NY 12239

Your complaint should be filed within **180 days** of when you first knew or should have known that the act or omission complained of occurred, unless you can show good cause for why you needed more time to file the complaint.

This section must identify the individual affected by the activity involved in the complaint. A contact number or address is needed in case additional information or clarification is required. **(Please Print Clearly)**

Social Security Number (last 4 digits): XXX-XX-	Date of Birth	Telephone Number

Last Name	First Name	M.I.

Street Address

City	State	Zip Code

What is your relationship to this person? ☐ **Self** ☐ **Parent or Guardian of child under 18** ☐ **Personal Representative**

(If you are a Personal Representative, please include a copy of documentation, such as a court order, power of attorney, health care proxy, or a Personal Representative designation form unless you already have provided documentation to the Department.)

What entity do you believe violated the health information privacy right or committed another violation of HIPAA requirements? Check appropriate box.

- ☐ NYS Department of Civil Service - Employee Health Service
- ☐ NYS Department of Civil Service - Employee Benefits Division (NYSHIP)
- ☐ NYS Department of Civil Service – Other Unit

The DCS Complaint Officer will review complaints about the Department's Employee Health Service, the Employee Benefits Division and the Department only. **If you have a complaint about a NYSHIP program administrator or insurer, you must contact them directly.**

When do you believe that the violation of your health information privacy right occurred?

LIST DATE(S): _____

Describe briefly what happened. How and why do you believe health information privacy rights were violated? Please be as specific as possible. (Attach additional pages as needed).

PLEASE SIGN AND DATE THIS FORM

SIGNATURE_____ **DATE**_____

PERSONAL PRIVACY PROTECTION NOTIFICATION - The information you provide on this form is requested for the principal purpose of filing a complaint to assert violations of the Health Insurance Portability and Accountability Act requirements pursuant to 45 CFR 164.530(d). The information will be used in accordance with Public Officers Law Section 96(1) of the Personal Privacy Protection Law. Failure to provide the information may prevent us from addressing your complaint. This information will be maintained by the Department of Civil Service, Complaint Officer, Albany, NY 12239; telephone (518) 473-2880. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375.