

PROTECTED HEALTH INFORMATION

Privacy Complaint

This form is for reporting facts pertaining to any known or suspected violation of your privacy rights, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records), and state statutes & regulations governing the privacy of your health information. WellPower, formerly Mental Health Center of Denver, takes the privacy of the people we serve very seriously. Our organization is committed to operating in a manner that promotes confidentiality of Protected Health Information (PHI).

Please be assured that information you share with us will be handled promptly. The PHI Privacy Officer will conduct a thorough investigation and the findings will be shared with you upon the completion of the investigation.

The completed form can be returned to the HISM Department by email at HISM@wellpower.org, by fax at (303) 504-6504, or in person/by postal mail to 4141 East Dickenson Place (Office 170), Denver, CO 80222, attention: HISM.

| | If you have questions, pled | ase call (303) 504-6510. | | |
|-------------------------------------|--|--------------------------|-------------------------|--------------|
| Please complete t | Person Served the following information about the | | elieved to be violated | |
| _, | | Last Name: | elleved to be violated. | |
| WellPower ID#: | | Date of Birth: | | (mm/dd/yyyy) |
| | Representative | | | I |
| If you are reporting on beha | (if applic alf of the person in services, please | | w Leave blank if not an | plicable |
| First Name: | | Last Name: | | priodicion |
| | Relationship | D: | | |
| | Your Contact I | nformation | | |
| Street Address: | C | ity, State: | Zip: | |
| Email: | | Phone: | | |
| | Complain | : Details | | |
| Describe how you think your privact | y rights have been violated: | | | |
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| X Decrease Sign of the | | | Cinn at us Date | |
| Requestor Signature | | | Signature Date | |