COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Privacy Complaint Form

Name**:** Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

Describe the act(s) or omission(s) that you believe violated privacy requirements and include the name(s) of any individual(s) who have knowledge of the act(s) or omission(s)**:**
Date and Place you believe act(s) or omission(s) occurred:

_____ _____
Your signature or Personal Representative's signature Date

_____
Print name

THE FOLLOWING INFORMATION IS NEEDED IF THE PERON SIGNING IS A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent): _____

For DMH Use

Date complaint received: _____ DMH location where complaint received: _____

Received by: _____ _____
printed name title

Any Privacy Complaint received by an area, site, facility or program must be date stamped and forwarded immediately to DMH Privacy Officer, 25 Staniford Street, Boston, MA 02114