Massachusetts Department of Public Health
Confidentiality Complaint Form

Name:_____

Address:_____

Telephone: _____ Date of Birth:_____

Please describe the nature of the complaint including dates of occurrence. Please name the DPH program, Bureau, or any individuals involved in your complaint.

_____

_____

_____

_____

_____

_____

Your Signature or Signature of Personal Representative Date

_____

Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information disclosed.

___ Person signing is the individual

___ Person signing is the Personal Representative authorized to make health care decisions for the individual. Describe the authority:_____

Please mail this form to:
Privacy Office
Massachusetts Dept. of Public Health
250 Washington St.
Boston, MA 02108

You may also contact:
Office for Civil Rights
US Dept. of Health and Human Services
Government Center
J.F. Kennedy Federal Building-Room 1875
Boston, MA 02203
Voice Phone (617) 565-1340
Fax (617) 565-3809 TDD (617) 565-1343

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