

**PRIVACY COMPLAINT BY A PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE**

**HBEX 406 (8/15)**



**Privacy Complaint Form  
 by a Parent, Guardian, or Authorized Representative**

You have the right, as the consumer's Authorized Representative to file a privacy complaint on behalf of the consumer with Covered California. This Privacy Complaint Form is to be used to report issues related to the consumer's privacy. Covered California may need to share this information with outside entities in order to investigate and resolve this complaint. Anyone may file a complaint. To submit this request, please complete all necessary items and mail the completed form and all relevant documents to:

Privacy Officer  
 1601 Exposition Blvd.  
 Sacramento, CA 95815

Consumer Information (As indicated on your Covered California Account)		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Covered California Case or Account Number:	Date of Birth:	

Parent, Guardian, or Authorized Representative's Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Daytime Phone Number <i>(Required)</i>	Email Address:	

What legal authority do you have to act on behalf of the Consumer? (Please attached legal documentation.)		
Parent <input type="checkbox"/>	Conservator <input type="checkbox"/>	Executor of Will <input type="checkbox"/>
Guardian <input type="checkbox"/>	Agent of Health Care <input type="checkbox"/>	Power of Attorney <input type="checkbox"/>
Other <input type="checkbox"/>		

<b>Attached Copy of Representative's Identifying Information.</b> <i>(If no identifying document is attached, your signature must be notarized.)</i>	
Driver's License	State Identification Card
Federal Issued Identification Card	Notary
Date Notarized:	UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
Notarized By:	
Notary Public Number:	

<b>Describe The Nature Of The Complaint</b>
<p>I have reason to believe that one or more of the following has occurred:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The organization/person has inappropriately disclosed their personal information.</li> <li><input type="checkbox"/> The organization/person has inappropriately used their personal information.</li> <li><input type="checkbox"/> The organization/person has inappropriately disposed their personal information.</li> <li><input type="checkbox"/> The organization/person has denied access to their personal information.</li> <li><input type="checkbox"/> The organization/person has denied their request to amend personal information.</li> <li><input type="checkbox"/> The organization/person has denied another privacy right.</li> <li><input type="checkbox"/> The organization's Privacy Policies or Procedures violate the law.</li> </ul>

<b>Consent To Refer This Complaint To Another Organization</b>
<p>Covered California may have to refer this complaint to another organization. Please choose one of the following.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I agree to have this complaint sent to another organization.</li> <li><input type="checkbox"/> I do not agree to have this complaint sent to another organization.</li> </ul>

**Consent To Disclose Name**

Please select one of the following options. *(Please note, not using your name may hinder Covered California's ability to resolve your complaint.)*

- I consent to my name being disclosed in order to resolve this complaint.
- I do not consent to my name being disclosed.

Please provide details of your complaint *(If necessary, attach a separate page):*

**Signature**

I understand Covered California may not be able to comply with my request, but will respond to my request.

I declare under penalty of perjury that the information on this form is true and correct.

Signature:

Date:

*The information requested on this form is required by the California Health Benefits Exchange, Privacy Office in order to process your request. The information you provide on this form is required to process your request and will be used by the Privacy Office for that purpose. Failure to provide this information may result in the denial of your request. Legal references authorizing the collection or maintenance of the information provided on this form include Sections 1798.22, 1798.25, 1798.27 and 1798.35 of the California Civil Code and Section 155.260(a) of the Code of Federal Regulations. California Health Benefits Exchange, Privacy Office, 1601 Exposition Blvd, Sacramento, CA 95815 (800) 889-3871.*