Privacy Complaint Form

Information & Instructions

On completion, this form should be sent to: **Ontario Telemedicine Network 438 University Ave., Suite 200, Toronto, ON M5G 2K8 Attention: Privacy and Risk Team**

Patient Information

Contact Information

FIRST NAME | LAST NAME | INITIALS

MAILING ADDRESS

CITY | PROVINCE | POSTAL CODE

TELEPHONE (including area code)

Representative Information (*complete only if you are acting on behalf of a patient*)

FIRST NAME | LAST NAME | INITIALS

MAILING ADDRESS

CITY | PROVINCE | POSTAL CODE

TELEPHONE (including area code) | BUSINESS TELEPHONE (including area code)

I have reason to believe that one or more of the following has occurred:

- ○ OTN has inappropriately collected my personal health information.
- ◉ OTN has inappropriately disclosed my personal health information.
- ○ OTN has inappropriately used my personal health information.
- ○ OTN has inappropriately disposed of my personal health information.
- ○ Other (please explain)

Please provide a detailed description of your privacy complaint covering the what, when, who, how, where and why of what happened. (If you need additional space, please attach as many pages as necessary).

SIGNATURE | DATE (DD-MMM-YYYY)

SIGNATURE OF REPRESENTATIVE | DATE (DD-MMM-YYYY)