# 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) _____