Receipt Number: **621548**

Thank you for contacting the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). OCR enforces federal civil rights laws which prohibit discrimination in the delivery of health and human services based on race, color, national origin, disability, age, sex, religion, and the exercise of conscience, and also enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security and Breach Notification Rules.

We are in the process of reviewing your correspondence. We will complete our initial review as quickly as possible.

If you have questions about the novel coronavirus, COVID-19, please go to the Centers for Disease Control website at https://www.cdc.gov.

For additional information about OCR, including the complaint review process, and our HIPAA, civil rights, and conscience regulations, please see the following links:

https://www.hhs.gov/ocr/complaints/index.html
https://www.hhs.gov/hipaa/index.html
https://www.hhs.gov/civil-rights/index.html

If you have any additional questions or need a reasonable accommodation, please contact OCR's Customer Response Center at 1-800-368-1019, Monday through Friday, 8:00 am to 6:00 pm, ET.

Sincerely,
Director, CCMO

English	If you speak a non-English language, call 1-800–368–1019 (TTY: 1-800-537-7697), and you will be connected to an interpreter who will assist you with this document at no cost.
Español - Spanish	Si usted habla español marque 1-800-368-1019 (o a la línea de teléfono por texto TTY 1-800-537-7697) y su llamada será conectada con un intérprete que le asistirá con este documento sin costo alguno.
中文 - Chinese	如果你讲中文，请拨打1-800-368-1019（打字电话：1-800-537-7697), 你将被连接到一位讲同语种的翻译员为你提供免费服务。
Tiếng Việt - Vietnamese	Nếu bạn nói tiếng Việt, xin gọi 1-800-368-1019 (TTY: 1-800-537-7697), và bạn sẽ được kết nối với một thông dịch viên, người này sẽ hỗ trợ bạn với tài liệu này miễn phí.
한국어 - Korean	한국어를 하시면 1-800-368-1019 (청각 장애용: 1-800-537-7697) 로 연락 주세요. 통역관과 연결해서 당신의 서류를 무료로 도와 드리겠습니다.
Tagalog (Filipino)	Kung ikaw ay nagsasalita nang Tagalog, tumawag sa 1-800-368-1019 (TTY: 1-800-537-7697) para makonek sa tagapagsalin na tutulong sa iyo sa dokumentong ito na walang bayad.
Русский - Russian	Если вы говорите по- русски, наберите 1-800-368-1019. Для клиентов с ограниченными слуховыми и речевыми возможностями: 1-800-537-7697), и вас соединят с русскоговорящим переводчиком, который вам поможет с этим документом безвозмездно.

Please indicate one of the following: Mr.

* First Name: Austin * Preferred Pronoun: * Last Name: Smith

* Preferred days/times to receive phone calls:

Phone: (945) 349-7412

Street Address Line 1:* 9131 FireSide Court

Street Address Line 2:

* City: Indianapolis

* State:Indiana Country:USA * ZIP: 46250 Email Address austin@asmithdev.com

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Have you previously filed a complaint with OCR? No

Are you filing this complaint for someone else? No

What agency or organization do you believe violated the Health Information Portability and Accountability Act (HIPAA) Privacy, Security or Breach Notification Rules? Please be aware that OCR does not have authority over individual workforce members.

Agency/Organization: Community North Hospital

* Street Address Line 1: 7150 Clearvista Drive

Street Address Line 2:

* City: Indianapolis

* State:Indiana Country:USA ZIP: 46256

Phone: (317) 621-6262

Email Address

Have you, or the person on whose behalf you are filing, been a client or patient of the agency or organization? Yes

Have you, or the person on whose behalf you are filing, been an employee of the agency or organization? No

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*** When do you believe that the violation of HIPAA occurred? A complaint must be filed no later than 180 days from when the complainant knew, or should have known, that the act or omission complained of occurred, unless this time limit is waived for good cause shown.?**

Date(s) Alleged Violation Occurred: Violation Date **Violation Date** 04/30/2025

How and why do you believe your (or someone else's) health information privacy rights were violated, or how another violation of HIPAA occurred? Please be as specific as possible.. (Attach additional pages as needed)

Community North Hospital was sent a formal written request for medical records on April 16th, 2025 in this request all medical records dating back to 2014 were requested, however the hospital only sent over psychiatric records and has refused to provide my medical records including the times I was in a medically induced coma under their care, Community North hospital has a conflict of interest as they engaged in medical malpractice and emailed me back in 2014 regarding this malpractice and offered me compensation, as of 2018 Community North has an affiliation with my former employer who is connected to a medical intelligence community in Indianapolis called the Indiana Mesh Coalition, members of my former employer have been engaged in stalking and death threats and Community North has repeatedly tried to claim I am mentally ill in order to protect my former employer and their cohorts, Community North has refused to provide my actual medical records and has only provided psychiatric records. An independent psychological evaluation outside of their network has confirmed I am not mentally ill and not a candidate for treatment, however when trying to request my medical records they have refused to provide any except psychiatric records and they are selectively releasing only certain records and ignoring several parts of my request for records which includes documents that were faxed by my aunt back in 2018 to the hospital. In 2018 the hospital retaliated against me and extended my stay simply for asking for a copy of my patient rights.

If your complaint involves an individual request for health records, was the request made in writing? Yes

Was the written request for health records made more than 60 days ago? No

Was the written request to send the health records to someone other than the requestor? No

Have you attempted to resolve this matter with the agency or organization against which you are filing? Yes

If yes, please describe your efforts and provide copies of any relevant documents.

I responded to them requesting the complete records, this is the 2nd time in the last year and a half that they have refused to release my medical records as requested, they have only selectively released records that harm my reputation and not ones showing my medical treatment for respiratory failure, medically induced coma, or any other medical procedure including a bone marrow biopsy, a lung biopsy and colonoscopy.

Do you have any witnesses? If yes, please provide name(s) and contact information.:

Witnesses

Witness name(s)	Email Address	Phone Number
Austin Smith	austin@asmithdev.com	(945) 349-7412

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act and their implementing regulations. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, discriminate or retaliate against you for filing a complaint or for taking any other action to enforce your rights under these Federal civil rights laws. OCR also collects information under authority of Section 1553 of the Affordable Care Act, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, as well as other Federal civil rights, conscience protections and religious liberty statutes. It may also be illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under these Federal laws. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html?language=es. To mail a complaint, please send to HHS Office for Civil Rights, Centralized Case Management Operations, 200 Independence Avenue, S.W., Suite 515F, HHH Building, Washington, D.C. 20201.

*** Signature:** AGREE: I have read, understand, and agree to the above.

Do you need special accommodations for OCR to communicate with you about this complaint?

No entries

If we cannot reach you directly, is there someone we can contact to help us reach you?

No entries

Have you filed your complaint anywhere else? If so, please provide the following . (Attach additional pages as needed)

Filed Elsewhere

Name(s) of agency/organization/court	Date Filed	Case Number (If known)

Has your complaint been accepted by the other agency/organization/court? No

Has there been a decision or a determination? No

To help us better serve the public, please provide the following information for the person you believe had their health information privacy rights violated (you or the person on whose behalf you are filing).

Ethnicity: Not Hispanic or Latino

Race:
- White

Primary Language Spoken (if other than English): English

CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about an individual, including personnel and medical records, when they are relevant to its investigation.

To investigate a complaint, OCR may need to disclose the individual's name and other identifying information about the individual to persons at the entity or agency under investigation or to other persons, agencies, or entities. In some circumstances, OCR may refer a complaint to another government agency, as warranted.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information and, with your consent, allows OCR to use an individual's name or other personal information, if necessary, to investigate a complaint.

Consent is voluntary, and it is not always needed in order to investigate a complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of the case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer a complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of a complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

OCR will use any applicable protections in that law to safeguard information which could identify an individual, or that, if released, could constitute a clearly unwarranted invasion of personal privacy. OCR may be required to release some information regarding the investigation of a complaint under the Freedom of Information Act (FOIA).

Please read and review the documents entitled Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Information in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of this complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- I understand that in the course of the investigation of this complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information which it has gathered as part of its investigation of this complaint.

- In addition, I understand that I may be covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because the individual has made a complaint, testified, assisted, in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS's investigation, conciliation, or enforcement process.

*** Consent Selection:**

CONSENT: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

Uploaded Files

	File Name	Size (Byte)	File Type
File Uploaded:	Records Request Community North.pdf	0	Complaint Description