



Complaints Under the HIPAA Privacy Rule, Mitigation, Refraining From Intimidating or Retaliatory Acts, and Waiver #1660.065

INITIAL EFFECTIVE DATE:	LAST REVISION DATE:	RESPONSIBLE UNIVERSITY DIVISION/DEPARTMENT
October 13, 2020	August 6, 2025	Office of Compliance and Integrity

POLICY STATEMENT

Florida International University (FIU) requires that each FIU Health Insurance Portability and Accountability Act (HIPAA) Hybrid Designated Components (hereinafter facilities and programs) receive complaints from individuals who believe FIU is not complying with the HIPAA Privacy Rule, FIU’s associated HIPAA Privacy Policies and Procedures, and any applicable federal laws or Florida state statutes governing the confidentiality, integrity and availability of PHI and electronic PHI (ePHI) and to provide further information in response to complaints.

An individual who believes a facility or program is not complying with the applicable requirements of the HIPAA Privacy Rule, federal law or Florida state statute may file a complaint with the facility or program Privacy Coordinator, the Director of Compliance and Privacy for Health Affairs, the FIU Office of General Counsel, the Office of Compliance and Integrity, and/or the Secretary of the U.S. Department of Health and Human Services (HHS).

FIU acknowledges that the Secretary of HHS is empowered to and may investigate any complaint. Accordingly, FIU will cooperate with any investigation or compliance review. FIU will keep records including pertinent policies, procedures, or practices and of the circumstances regarding any alleged violation. FIU will submit compliance reports or corrective action plans, in a timely manner as requested by the Secretary of HHS.

FIU’s Office of Compliance and Integrity and the Division of Information Technology, in cooperation with appropriate facility and program Privacy and Security Coordinators will investigate alleged violation of FIU’s HIPAA Privacy and Security Rule Policies and Procedures consistent with the requirements of FIU’s Reporting of HIPAA Incidents and Notification in Cases of Breaches Policy and Procedure #1660.095, and the FIU Incident Response Plan.

FIU will include contact information for filing a complaint in its Notice of Privacy Practices. The contact information will include the name, title, and telephone number of the FIU Director of Compliance and Privacy for Health Affairs with the Office of Compliance and Integrity.

FIU Workforce members and its Business Associates will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for exercising any right established under the HIPAA Privacy and Security Rule, FIU's associated HIPAA Privacy and Security Policies and Procedures, or for participation in any process provided by the HIPAA Privacy and Security Rule, FIU's associated HIPAA Privacy and Security Policies and Procedures, including the filing of a complaint; and FIU and its Business Associates will not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any individual for:

- (1) Filing of a complaint with the Secretary of HHS;
- (2) Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing regarding the HIPAA Privacy and/or Security Rules and FIU's associated HIPAA Privacy and Security Policies and Procedures, or
- (3) Opposing any act or practice made unlawful under the HIPAA Privacy and/or Security Rules, provided the individual has a good faith belief that the practice opposed is unlawful or in violation of FIU HIPAA Privacy and/or Security Policies and Procedures, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of the Privacy and Security Rules.

FIU and the FIU facilities and programs will not require an individual who is the subject of the PHI who believes FIU and/or an FIU facility, program, or Business Associate is not in compliance with, or has not complied with the HIPAA Privacy and/or Security Rules, federal law and/or Florida state statute to waive their right to file a complaint with the Secretary of HHS as a condition of the provision of treatment, payment or eligibility for benefits.

As a University-wide policy and procedure, this policy and procedure takes precedence over any facility or program-specific policies, procedures, or protocols that conflict with this policy and procedure, unless prior approval is obtained from the Office of Compliance and Integrity. (FIU Policy and Procedure #1660.080) (Policies and Procedures, Changes to Policies and Procedures, and Documentation)

Facilities and programs may maintain HIPAA documentation in either paper or electronic form, provided that any format is sufficiently protected to ensure it will be retrievable throughout the required retention period. Unless otherwise indicated in FIU Privacy and Security Rule Policy and Procedure, the facility or program Privacy Coordinator will be responsible for maintaining all HIPAA documentation relevant to his/her facility or program. (FIU Policy and Procedure #1660.080) (Policies and Procedures, Changes to Policies and Procedures, and Documentation)

All facility and program Workforce members shall receive mandatory HIPAA Privacy and Security Rule training. (FIU Policy and Procedure # 1660.075) (HIPAA Privacy and Security Rule Training)



Workforce members who fail to adhere to this policy and procedure may be subject to civil and criminal penalties as provided by law, and/or administrative and disciplinary action. (FIU Policy and Procedure #1660.085) (Sanctions)

FIU reserves the right to amend, change or terminate this policy and procedure at any time, either prospectively or retroactively, without notice. Any ambiguities between this policy and procedure and the other policies and procedures should be accordingly made consistent with the requirements of HIPAA and Florida state statutes. (FIU Policy and Procedure #1660.080) (Policies and Procedures, Changes to Policies and Procedures, and Documentation)

SCOPE

This policy applies to FIU facilities and programs contained within FIU’s HIPAA Hybrid Designation (Policy and Procedure #1610.005), its Workforce members and Business Associates as defined in this policy and FIU Policy and Procedure #1660.015 regarding Business Associates Agreements.

REASON FOR POLICY

To establish procedures necessary for individuals to file complaints and report known or suspected violations related to the HIPAA Privacy and Security Rule, federal law, Florida state statutes, and FIU’s HIPAA Privacy and Security Policies and Procedures.

DEFINITIONS

Please refer to the following link for a complete list of definitions pertaining to all HIPAA policies.

[HIPAA Policies Definitions](#)

ROLES AND RESPONSIBILITIES

Compliance Oversight: The Director of Compliance and Privacy for Health Affairs:

- Evaluates all federal and state healthcare privacy laws, regulations, rules and ordinances (Rules) to ensure compliance with the Rules.
- Develops and maintains all required University-wide Privacy Rule policies and procedures.
- Develops and maintains HIPAA health care Privacy Rule training modules.
- Performs audits and assessments of the facilities and programs to ensure their compliance with the Privacy Rules and associated FIU Policies and Procedures.

- Partners with the Division of Information Technology HIPAA Security Officer to ensure compliance with all federal and state healthcare privacy and security laws, regulations rules, and ordinances.

HIPAA Components (Facilities and Programs):

- The FIU HIPAA Hybrid Designated Components (facilities and programs) must designate a Privacy Coordinator responsible for overseeing and ensuring the facility's or program's implementation and compliance with the HIPAA Privacy Rule, FIU's associated HIPAA Privacy Policies and Procedures, and any applicable state laws and/or regulations governing the confidentiality, integrity and availability of PHI and electronic PHI (ePHI), including, but not limited to processing and handling complaints under the HIPAA Privacy Rule.

RELATED RESOURCES

References

- 45 CFR §164.502
- 45 CFR §164.504
- 45 CFR §164.524
- 45 CFR §164.526
- 45 CFR §164.528
- Florida Statute §95.11

Related Policies

- FIU Policy # 1610.005 (Designated Health Care Components of FIU Community)
- FIU Policy and Procedure #1660.070 (Designation of HIPAA Privacy Officer and Facility or program Privacy and Security Coordinators)
- FIU Policy and Procedure #1660.085 (Sanctions)
- FIU Policy and Procedure #1660.075 (HIPAA Privacy and Security Rule Training)
- FIU Policy and Procedure #1660.015 (Business Associate Agreements)
- FIU Policy and Procedure #1660.080 (Policies and Procedures, Changes to Policies and Procedures, and Documentation)
- FIU Policy and Procedure #1660.040 (Verification)
- FIU Policy and Procedure #1660.095 (Reporting of HIPAA Incidents and Notification in Cases of Breaches)
- FIU Policy and Procedure #1660.080 (Policies and Procedures, Changes to Policies and Procedures, and Documentation)

CONTACTS



For further information concerning this policy, please contact the Director of Compliance and Privacy for Health Affairs at (305) 348-0622 or hipaaprivacy@fiu.edu, or contact the appropriate Component Privacy Coordinator.

HISTORY

Initial Effective Date: October 13, 2020

Review Dates (*review performed, no updates*): n/a

Revision Dates (*review performed, updates made to document*): October 13, 2020; February 29, 2024; August 6, 2025.



Complaints Under the HIPAA Privacy Rule, Mitigation, Refraining From Intimidating or Retaliatory Acts, and Waiver #1660.065a

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PROCEDURES

I. Receiving and Processing HIPAA Privacy Rule, Federal Privacy and/or Florida State Statute Privacy Complaints

Facility and program Privacy Coordinators are responsible for overseeing and ensuring the facility’s and program’s implementation and compliance with the HIPAA Privacy Rule, federal law, Florida state statute, and FIU’s associated HIPAA Privacy Rule Policies and Procedures governing the confidentiality, integrity and availability of PHI and electronic PHI (ePHI), including, but not limited to accepting and processing patient complaints, mitigating, to the extent practicable, any harmful effect that is known to the facility or program of a use or disclosure of PHI/ePHI in violation of the HIPAA Privacy Rule and FIU’s associated HIPAA Privacy Rule Policies and Procedures, ensuring Workforce members and Business Associates refrain from intimidating and retaliatory acts against individuals for exercising any right established under the HIPAA Privacy Rule, federal law, Florida state statutes, and FIU’s associated HIPAA Privacy Rule Policies and Procedures, or for participation in any process provided by the HIPAA Privacy Rule, federal law, Florida state statutes, and FIU’s associated HIPAA Privacy Rule Policies and Procedures, including the filing of a complaint, and that individuals are not required to waive their right to file a complaint with the Secretary of the federal Department of Health and Human Services (HHS) as a condition of the provision of treatment, payment or eligibility for benefits. Privacy Coordinators may delegate and share duties and responsibilities as necessary and appropriate but retain oversight responsibility. (FIU Policy and Procedure #1660.070) (Designation of HIPAA Privacy Officer and Facility or program Privacy and Security Coordinators)

- A. The Director of Compliance and Privacy for Health Affairs with the Office of Compliance and Integrity (Designated HIPAA Privacy Officer) and the facility or program Privacy Coordinator’s contact information (i.e., names, telephone numbers and office addresses) must be conspicuously posted in each facility and program.
- B. The Privacy Coordinator will be directly accountable to their facility or program Administrative Officer(s) to whom he/she reports (e.g., CEO, Provost, Dean or Director) for proper and careful handling of patient complaints and questions.
- C. The Privacy Coordinator will use the usual facility or program processes to provide patient satisfaction and improve patient care on an informal basis.

- D. For concerns and questions that can be answered and resolved at the facility or program level, no other review process is needed.
- E. The Privacy Coordinator may consult with the Director of Compliance and Privacy for Health Affairs to assist in resolving and responding to privacy complaints and questions.
- F. The Privacy Coordinator must document the receipt and disposition of all complaints received within their facility or program.
- G. If a complaint or question cannot be resolved to the satisfaction of the patient at the facility or program level or, if at any time, the patient indicates that he/she wishes to make a written complaint related to a HIPAA Privacy Rule or FIU's associated HIPAA Privacy Rule Policies and Procedures, the following procedures will be followed:
 - 1. The Privacy Coordinator will provide the patient with the "Patient Complaint Form", with instructions on how to complete and file the complaint. (See Sample Patient Complaint Form attached). However, the Privacy Coordinator will accept all written complaints if the required information as required on the Patient Complaint Form is provided.
 - 2. The written complaint may be filed with the facility or program, the Director of Compliance and Privacy for Health Affairs, or the Office of Compliance and Integrity, as identified in FIU Policy and Procedure #1660.095 (Reporting of HIPAA Incidents and Notification in the Case of a Breach).
 - 3. If the written complaint is filed with the facility or program, the Privacy Coordinator must:
 - a. Document receipt of the complaint on the day received,
 - b. Document the name and title of the Privacy Coordinator who received the complaint, and
 - c. Timely provide a copy of the complaint to the Director of Compliance and Privacy for Health Affairs.
 - 4. The Director of Compliance and Privacy for Health Affairs will, as necessary and appropriate, adhere to the procedures identified in FIU Policy and Procedure #1660.095 (Reporting of HIPAA Incidents and Notification in the Case of a Breach).
- H. If the complaint or question cannot be resolved to the satisfaction of the patient at the facility or program level or, if at any time, the patient indicates that he/she wishes to make a verbal complaint related to the HIPAA Privacy Rule or FIU's associated

HIPAA Privacy Rule Policies and Procedures, the following procedures will be followed:

1. The Privacy Coordinator will:
 - a. Request and document the name and contact information for the patient,
 - b. Document the date, title and name of the Privacy Coordinator who received the complaint,
 - c. Document the basis of the complaint,
 - d. Provide the patient the contact information for the Office of Compliance and Integrity, the FIU “Ethical Panther line” at <https://compliance.fiu.edu/hotline>, and
 - e. Timely provide the Director of Compliance and Privacy for Health Affairs with a copy of any and all information the patient provided.

 2. The Director of Compliance and Privacy for Health Affairs will, as necessary and appropriate, adhere to the procedures identified in FIU Policy and Procedure #1660.095 (Reporting of HIPAA Incidents and Notification in the Case of a Breach).
- I. Investigative Reports to facility or program Administrative Officer(s) (e.g., CEO, Provost, Dean or Director)
1. Upon completion of an investigation by the Office of Compliance and Integrity, the Director of Compliance and Privacy for Health Affairs will timely notify and provide a copy of all Investigative Reports to the Administrative Officer(s) of the facility or program generated in response to formal patient complaints filed against the facility or program as outlined in FIU Policy and Procedure #1660.095 (Reporting of HIPAA Incidents and Notification in the Case of a Breach).

 2. The Director of Compliance and Privacy for Health Affairs will periodically provide the facility or program Administrative Officers with information regarding the number, nature, and resolution of complaints received by the Office of Compliance and Integrity related to their facility or program.

II. Mitigation

- A. The Director of Compliance and Privacy for Health Affairs, the HIPAA Security Officer, the Office of General Counsel, the facility or program Privacy and Security Coordinators, and other FIU Workforce members, as deemed necessary and appropriate, will work collaboratively to mitigate, to the extent practicable, any harmful effect that is known to FIU of a use or disclosure of PHI/ePHI in violation of the HIPAA Privacy and Security Rule, federal law, Florida state statutes, and FIU’s associated HIPAA Privacy Policies and Procedures governing the confidentiality, integrity and availability of PHI and electronic PHI (ePHI) by an FIU Workforce member(s) or its Business Associate(s). Mitigation may include retrieving, deleting, or

destroying improperly disclosed PHI; terminating access or changing passwords; remote wiping mobile devices; modifying policies or practices; warning recipients of potential penalties for further violations. In some cases, it might include paying for the cost of a credit monitoring service or similar action, and/or notifying affected individuals even if the breach is not required to be reported under the breach notification rules.

- B. The Dedicated Investigator(s) will:
1. Document in the Final Investigative Report file:
 - a. The dates, names, and titles of those involved in mitigation efforts and,
 - b. The mitigation efforts and outcomes.
 2. Properly secure all written communications sent and received among the Investigative team regarding the mitigation efforts and outcomes, and
 3. Properly secure any and all written communications sent to or received from individuals adversely or potentially adversely impacted by the alleged violation or breach. (FIU Policy and Procedure #1660.095) (Reporting of HIPAA Incidents and Notification in the Case of a Breach).

III. Refraining From intimidating or Retaliatory Acts

Complainants/Witnesses

- A. FIU Workforce members, Business Associates, and students must refrain from intimidation and retaliation against any individual or other person for:
- Filing a complaint with the Secretary of the federal Department of Health and Human Services
 - Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or
 - Opposing any act or practice made unlawful by the HIPAA Privacy or Security Rules, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of protected health information.
- B. FIU will not take any administrative or disciplinary action (sanction) or retaliate against Workforce members or Business Associates who disclose patient PHI, provided:
1. The Workforce member or Business Associate has a good faith belief that a facility or program engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided potentially endangered one or more patients, workers, or the public; and
 2. The disclosure is to:
 - a. A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the

facility or program or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the facility or program; or

- b. An attorney retained by or on behalf of the Workforce member or Business Associate for the purpose of determining the legal options of the Workforce member or Business Associate with regard to conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided potentially endangered one or more patients, workers, or the public.

Workforce Members who are Victims of Crime

- C. FIU will not sanction or retaliate against Workforce members who discloses patient PHI, if the Workforce member is the victim of a criminal act and he/she discloses the PHI to a law enforcement official, provided that:
 - 1. The PHI disclosed is about the suspected perpetrator of the criminal act; and
 - 2. The PHI disclosed is limited to the suspected perpetrator's:
 - a. Name and address.
 - b. Date and place of birth.
 - c. Social security number.
 - d. ABO blood type and rh factor.
 - e. Type of injury.
 - f. Date and time of treatment.
 - g. Date and time of death, if applicable.
 - h. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos, and
 - 3. The Workforce member did not disclose for the purposes of identification or location any PHI related to the suspected perpetrator's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

IV. Waiver

- A. See Policy Statement

V. Forms

- Sample Patient Complaint Form

VI. Record/Documentation Retention

- A. If a communication, action, activity, or designation is required to be documented in writing, the document or record owner (The facility or program) will maintain such writings, or an electronic copy, for seven (7) years m the date of its creation or the last



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effective date, whichever is later. (FIU Policy and Procedure #1660.080) (Policies and Procedures, Changes to Policies and Procedures, and Documentation)