

PRIVACY COMPLAINT

Please print all requested information to prevent delays in our response & provide completed form to your facility.

Patient Name:

Last First MI Maiden or Other Name

Address: _____

City: _____ ST: _____ Zip: _____

Date of Birth: _____ - _____ - _____ Phone: (____) _____

My privacy complaint involves:

- Appropriateness of privacy policies and processes
- My privacy rights (example: privacy notice, authorization, access, amend, request restrictions, confidential communications or accounting of disclosures)
- Inappropriate handling of protected health information
- Other (Please provide a detailed description of the privacy issue:

Date of incident (if applicable): _____

Name of employee(s) and / or location where incident occurred (if applicable):

SIGNATURE OF INDIVIDUAL DATE OR SIGNATURE OF PERSONAL REPRESENTATIVE DATE

RELATIONSHIP TO INDIVIDUAL

FOR INTERNAL USE ONLY

Complete this section and retain with patient records.

Staff member who responded Title Phone

Facility Name