

PATIENT COMPLAINT – PRIVACY VIOLATION (Please Print)

PATIENT INFORMATION				
Patient's last name:	First:	Middle Initial:	Birth date:	Sex : <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security:	
City:	State:	ZIP Code:	Home phone:	Cell phone:
PERSON/ORGANIZATION WHO VIOLATED PRIVACY RIGHTS				
Name of Practitioner/Clinic:				
Address:				
City:	State:	Zip Code:	Phone: ()	
WHEN AND HOW DID THIS VIOLATION HAPPEN				
<i>To the extent that you can remember, identify the date(s) of the unlawful use or disclosure of your health information:</i>				
On This Date: _____ On these dates: From: _____ To: _____				
<i>Briefly describe what happened. How and why do you believe a person or organization unlawfully disclosed health information:</i>				
OTHER REPORTS				
<i>Have you filed your complaint with anyone else?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please identify the Person/Organization and Date the report was filed.				
Who:			Date:	
YOUR RIGHT TO COMPLAIN				
I understand that no one will retaliate against me for exercising my right to complain about privacy violations. I also understand that I may notify the Secretary of the U.S. Department of Health and Human Services of my complaint.				
Patient/Authorized signature:				
				Date:
<i>If signed by person other than patient print Name of Authorized Person and relation to patient and authority to authorize:</i>				
FOR OFFICE USE ONLY				
Date Received:		Date Resolved:		
Name and Title of Person who Investigated this Complaint:				