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 PATIENT **DATE**

OR

PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON **DATE**

RELATIONSHIP TO PATIENT **DATE**

REQUEST for CONFIDENTIAL HANDLING of PROTECTED HEALTH INFORMATION (PHI)

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FOR INTERNAL USE ONLY

Complete this section and retain with patient records.

Associate who responded	**Title**	**Phone**

Facility Name