

Complaint Concerning Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 you have a right to complain about our privacy policies, procedures or actions. This medical practice will not engage in any discriminatory or other retaliatory behavior against you because of this complaint. Please be as thorough and forthright as possible, and return it to our Privacy Officer.

Please complete the sections below:

Name:
Address:
Phone:
E-mail Address:
What is the best way to reach you?
What are the best hours to reach you?

Details of your complaint: *(Please be as specific as possible with dates, times and the specific policy, procedure or action taken; include the names, if any, of any one in the office with whom you discussed this. Use the other side of this form if you need more room. Attach any relevant documents.)*

Documents attached include:

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____