[Insert Letterhead]

**Privacy Complaint Form**

Please complete this form and give it to the Privacy Officer.

|  |  |
| --- | --- |
| Date Complaint Submitted: |  |
|  |  |
| Name and Address: |  |
|  |  |
| Telephone Number: |  |
| Medical Record Number: |  |
| Date of Birth: |  |

|  |  |
| --- | --- |
| Date of Occurrence: |  |
|  |  |
| Name of patient involved in occurrence (if different than set forth above): |  |
|  |  |
|  |  |
| Description of facts forming the basis of the Complaint: |  |
|  |  |
|  |  |

|  |
| --- |
| Signature of patient or personal representative (and relationship of personal representative) |

For [Insert Covered Entity name] Use Only

Name of person receiving Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Complaint received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Receipt of Complaint sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Privacy Officer/Designee Date