

Complaint Regarding Uses or Disclosures of Health Information

Name: _____ Social Security Number: _____

Primary Physician: _____ Date of Request: _____

I hereby request to file a complaint regarding a disclosure(s) of my protected health information. The following is a description of the incident:

[Please provide the following: date(s) of the incident(s), physician or staff involved, the individual(s) or organization receiving the information, the information disclosed and other pertinent information that you believe will assist us in our investigation of the incident(s).]

Signature of the Patient: _____

Signature of Guarantor: _____
(Sign If Patient Is A Minor)

Date received by Site Compliance Contact/Office Manager: _____

Investigation Performed by: _____

Details of Investigation:

Date Response Sent to Patient: _____

Patient notified by:

Mail Courier UPS Certified

Patient Picked Up: _____
(Signature of Patient)

Verbal Discussion: _____
(Staff signature)

Date: _____