# HIPAA COMPLAINT FORM

Please be assured that your complaint will be kept confidential. You may use the space provided below to describe your complaint. It is our intent to use this feedback to better protect your rights to patient confidentiality.

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Name of Patient (print)_____Date_____

Patient/Sponsor Identification or SSN _____

Signature of Patient _____Date_____

Complaint Received By: _____Date_____

Privacy Officer Notified: YES NO Date _____