

Privacy Complaint Form

Today's Date: _____

Patient's Name: _____

Birth Date: _____ Patient Account number: _____

Patient's Address: _____

Description of the acts or omissions believed to be in violation of the privacy.

Dates on which the acts or omissions are believed to have occurred:

Describe the protected health information affected.

Do you know of anyone who may have received protected health information?

Yes _____ No _____

If yes, who? _____

Signature of parent or guardian or patient if over 18

Date

Signature of employee

Date

For The Children's Medical Group Use Only

Have the CMG policies and procedures been violated? Yes ___ No ___

Does there need to be changes to the existing policies and procedures?

Yes ___ No ___

Do policies and procedures need to be created? Yes _____ No _____

Comments:
