PATIENT PRIVACY COMPLAINT
AND
RESOLUTION FORM (HIPAA)

COMPLAINANT NAME **DATE OF COMPLAINT** ***(when reported)***

Address-City/State/Zip

Phone **Fax** **email**

DESCRIPTION OF COMPLAINT

INITIAL RESPONSE TO COMPLAINANT (to be completed by FMOA)

ACTION TO BE TAKEN TO PREVENT RECURRENCE (to be completed by FMOA) *BY WHOM?*

EMPLOYEE RECEIVING COMPLAINT COMPLIANCE / PRIVACY OFFICER