COMPLAINT FILING FORM

HIPAA PRIVACY

DATE:	FILE NUMBER:

You may submit your complaint to:

Anna Scott
Privacy Officer
163 May St.
Bishop, CA 93514

NOTICE: The information you provide here will remain confidential to the extent possible. We may need to divulge the information in order to investigate your claim. Anyone may file a complaint.

YOUR INFORMATION			
Last Name:	First Name:	MI:	
Address:			
City:	State:	Zip Code:	
Email Address:	Daytime Phone:	Evening Phone:	
Best Way to Reach You:	Best Hours to Reach You:		

EMPLOYEES ONLY:		
Department:	Division:	Supervisor:

INFORMATION ABOUT YOUR COMPLAINT	
The department your complaint is against:	
The person your complaint is against:	
Date you first noticed action/violation:	
Date(s) action(s) occurred:	

DETAILS OF THE COMPLAINT:

I have reason to believe that one or more of the following has occurred:

- ☐ The department/person has inappropriately disclosed my personal health information
- ☐ The department/person has inappropriately used my personal health information
- ☐ The department/person has inappropriately disposed of my personal health information
- ☐ The department/person has denied access to my personal health information
- ☐ The department/person has denied my amendment to my personal health information
- ☐ The department's privacy policies and procedures violate HIPAA requirements

DESCRIBE YOUR COMPLAINT:

Please include *what, when, who, how, where, and if you know, why* about the incident(s). You may attach additional pages if necessary.

4. WITNESSES		
DO YOU HAVE WITNESSES TO THE INCIDENT (s)? ☐ NO ☐ YES		
Witness Name:	Address:	Phone Number:
Witness Name:	Address:	Phone Number:
Witness Name:	Address:	Phone Number:

5. RESOLUTION OF YOUR COMPLAINT
Please describe how your complaint could be resolved:

6. YOUR SIGNATURE
The information I have provided is true and correct to the best of my knowledge. SIGNATURE: DATE: