Adams County Memorial Hospital and its Divisions
P.O. Box 151, Decatur, IN 46733 (260) 724-2145

Privacy Complaint Form

1. Date of this complaint: _____
2. Date(s) that you believe this breach of confidentiality or violation of privacy rights occurred:
   _____
3. Location of breach or violation: _____
4. Name of person whose confidentiality was breached and/or whose privacy rights were violated:
   _____
5. Name of person completing this form, if other than the person named above, and the relationship:
   _____
6. Briefly describe what you believe happened and why this constitutes a breach of confidentiality or a violation of privacy rights: _____
   _____
   _____
   _____
7. How did you become aware of this breach or violation?
   _____
   _____
8. Who, if anyone, do you think may have been responsible for this breach or violation?
   _____
9. What harm do you believe may have been caused by this breach or violation?
   _____
   _____
10. What do you feel can be done to lessen any harm that may have occurred as a result of the breach or violation? _____
    _____
    _____
11. Other comments: _____
    _____
12. Phone number where someone can contact you to discuss your concerns: _____

_____ _____
Signature Date

_____
Printed Name