



KEEP A COPY FOR YOUR RECORDS

HIPAA PERSONAL HEALTH INFORMATION PRIVACY COMPLAINT REPORT

Today's Date: / /	First Name:	Last Name:
Street Address:		
City:	State:	Zip Code:
Home Phone: () -	Work Phone: () -	
Fax (if available): () -	Email Address (if available):	
Are you filing this complaint for someone else? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, whose health information privacy rights do you believe were violated?		
First Name:	Last Name:	Your Relationship:

Information about Suspected Privacy Violation:

Enter the information regarding the individual or organization that you believe violated HIPAA Personal Health Information privacy requirements.

Person/Agency/Organization:		
Street Address:		City:
State:	Zip Code:	Phone: () -
Date of Suspected Privacy Violation: / /		
Please describe in detail the nature of your privacy complaint:		

Signature: _____ Date: ____/____/____

CN 009.034
June 2009
Human Resources

Mail to:
ChildNet HIPAA Client
Resource Coordinator
313 N. State Road 7
Plantation, FL 33317
Or email hipaa@childnet.us



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For Internal Use Only:

Date and Time Received: / / <input type="checkbox"/> AM <input type="checkbox"/> PM	Assigned Privacy Complaint Number: #
Complaint Delivered by: <input type="checkbox"/> Mail <input type="checkbox"/> Personal Delivery <input type="checkbox"/> Email <input type="checkbox"/> Fax	
Process of Investigation:	
Formal Action Taken/Resolution:	
Additional Comments by HIPAA Client Resource Coordinator:	

HIPAA Client Resource Coordinator

Date