



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](mailto: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**