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)* ☐ Yes ☐ 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: ____/___/_____

Mail to:
ChildNet
HIPAA Client Resource Coordinator
1100 W. McNab Road
Ft. Lauderdale, FL 33309

Or Email: hipaa@childnet.us

For Internal Use Only:

Date and Time Received: ☐ AM ☐ PM	Assigned Privacy Complaint Number:
Complaint Delivered by: Mail ☐ Personal Delivery ☐ Email ☐ Fax ☐	
Process of Investigation:	
Formal Action Taken/Resolution:	
Additional Comments by HIPAA Client Resource Coordinator:	

_____ _____

HIPAA Client Resource Coordinator **Date**