530.541.3420 TEL
bartonhealth.org

COMPLAINT CONCERNING PRIVACY PRACTICES

Please address your complaint to: _____ , Privacy Officer

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to complain about our privacy policies, practices, or acts. We will not engage in any discriminatory or retaliatory behavior against you because of this complaint. Please be as thorough as possible and return this form to our Privacy Officer at the address listed above.

Please complete the sections below:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email Address: _____

What is the best way to reach you? _____

What are the best hours to reach you?_____

Details of your complaint: (*Provide specific details, including dates, times, and circumstances. Include the names, if any, of anyone with whom you discussed your complaint. Additional sheets may be used if needed, and relevant documents should be attached.)*

_____

_____

_____

_____

Documents attached include: _____

Patient, Guardian or Responsible Party Signature: _____

Printed Name: _____ Relationship: _____

Patient Name: _____ Date of Birth (MM/DD/YYYY): _____

Date Signed (MM/DD/YYYY): _____ Time: _____

OFFICE USE ONLY

Date received: _____ Complaint Number: _____

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