

Parkside Pediatrics Privacy Complaint Form

Today's Date: _____

Patient's Name: _____

Birth Date: _____ Patient Account number: _____

Patient's Address: _____

Description of the acts or omissions believed to be in violation of the privacy.

Dates on which the acts or omissions are believed to have occurred:

Describe the protected health information affected.

Do you know of anyone who may have received protected health information?

Yes _____ No _____

If yes, who? _____

Signature of parent or guardian or patient if over 18

Date

Signature of employee

Date

For Parkside Pediatric Use Only

Have the PsP policies and procedures been violated? Yes ___ No ___

Does there need to be changes to the existing policies and procedures?

Yes ___ No ___

Do policies and procedures need to be created? Yes _____ No _____

Comments:

