PATIENT COMPLAINT FORM

(Saint Louis University)

Today's Date:

Patient Name: **Medical Record #:**

Birth Date:

Patient Address:

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

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 Patient or Legal Representative: **Date:**

Description of Representative's Authority

FOR INTERNAL USE ONLY

Have Saint Louis University policies and procedures been violated? Yes _____ No _____

Does a change need to be made to existing policy and procedure? Yes _____ No _____

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

Comments:

Signature of Staff Person: **Date:**

Print Name and Title: