Health Care Component: ____________________________

Unit Privacy Officer: _________________________________

HIPAA Complaint Process

Instructions: Please print and sign the form.

Patient Name: ____

Patient Address: ___________________________________ City, State, Zip Code: ____________________________

Today's Date: _____/_____/_____

Dates acts or omissions are believed to have occurred:

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

Please describe the Protected Health Information affected.

Do you know of any unauthorized person or unauthorized agency who may have received your PHI?

Yes No

If so, please specify the name and address of the organization or individual:

____ ___ /___ /___
Signature of Patient or Legal Representative Date

Missouri State University Use Only

____ No Violation occurred *1
____ No Violation occurred *2
____ No Violation occurred *3
____ No Violation occurred *4

* Disposition Code

_______________________________________ ___ /___ /___
University Privacy Officer Signature Date

Appeal of HCC-based complaint opportunity

I ____ agree ____ disagree (check one) with the resolution.
If I disagree, I ____ do, ____ do not (check one) request that complaint be forwarded to the University Privacy Officer for review.

_______________________________________ ___ /___ /___
Signature of Patient or Legal Representative Date

_______________________________________ By _______________________________________
Date received by University Privacy Officer University Privacy Officer or Designee

HIPAA Procedure 1.140, Form 1