

### COMPLAINT REPORT

This is a voluntary form. At the discretion of the Client Rights staff or HIPAA Privacy Officer, a complaint may be filed orally. This information is used only for investigation and resolution of this complaint.

If you have any questions regarding this form or need assistance in the completion of it, contact the facility's Client Rights staff or Privacy Officer.

Name - Patient / Client (Last, First MI)	Name - Complainant (Last, First MI) (if not patient / client)
Address	Address
Telephone Number(s)	Telephone Number(s)
Facility / Unit	

This complaint alleges violation of:  item \_\_\_\_\_ of the Patient Rights in Chapter 51 WSS.  
or (Give Number, if known)  
 the federal Health Insurance Portability and Accountability Act (HIPAA – 45 CFR § 164),  
regarding the use and disclosure of patient's protected health information.

**DESCRIBE YOUR COMPLAINT**

State all facts, including time, place of incident, names of other involved, witnesses, if any.

RELIEF SOUGHT (Not applicable for HIPAA Complaints)

I have also submitted this complaint to the following agency: \_\_\_\_\_

**If this issue relates to or involves a possible violation of HIPAA, the facility Privacy Officer must be notified**

**SIGNATURE:** \_\_\_\_\_ Date - Submitted: \_\_\_\_\_  
(Person Completing Report)

Date - Received: \_\_\_\_\_

**DISTRIBUTION**  
Original - Facility Client Rights      Copy - Client