Patient Complaint Form

This office values the privacy of its patients and is committed to ensuring that all health information is protected as required by the HIPAA regulations.

Please use the space below to document your complaint or concerno retaliation for providing this information.	n. Please be assured there will
-	
D.C. AM. (DI. C.)	
Patient Name (Please print)	
Patient Signature	Date
Phone Number	_

See reverse side for results of the investigation

Investigation Results	
-	
Office Manager/Privacy Officer/Security Officer	Date
☐ Patient notified of results of investigation. HR issues will not b	e discussed
By:	
Date:	
Time:	