

**Attachment 44
Complaint Form**

Effective Date: April 14, 2003

Any person has the right to file a complaint if the person believes that a University of Miami workforce member has not adequately protected the health information entrusted to us or ensured patient rights with respect to their health information. To file a complaint, you may complete this form and return it to the University of Miami Office of HIPAA Privacy & Security. It may be mailed to PO Box 019132 (M-879), Miami, FL 33101 or personally delivered to the office located in the Professional Arts Center Building at 1150 NW 14th Street, Suite 409. This complaint will apply to the department/office you list below.

Please provide the following information:

Patient Name: _____ Date of Birth: _____

Medical Record Number: _____ Last 4 Digits of SSN: _____

Address: _____

I am submitting a complaint about (please check all that apply):

- Department: _____
- Physician: _____
- Hospital: _____
- Office: _____
- Location: _____
- Name of Employee at Issue: _____

Please describe the privacy concern (attach additional pages as necessary):

Signature of Individual Filing Complaint

Date

Printed Name of Individual Filing Complaint

Contact Phone Number

Street Address

City

State

Zip Code

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) hipaaprivacy@med.miami.edu
Miami, FL 33101 305-243-5000 1-866-366-4874

COMPLAINT FORM



Form
D3900042E

Revised
6/10/11

NAME: _____

MRN: _____

LAST 4 DIGITS OF SSN: _____

DOB: ____/____/____

DATE: _____

TIME: _____