



For Internal Use Only
Tracking Number _____

PRIVACY COMPLAINT FORM
For Patient Use Only

If you have questions about completing this form, please call 214-648-6080 and leave a message.

Date _____

Your First Name _____ Your Last Name _____

Home Phone(____) _____ Work Phone(____) _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Date of Birth _____

Are you filing this complaint for someone else? Yes No *(if no, go to next section)*
If yes, whose health information privacy rights do you believe were violated?

Patient's First Name _____ Patient's Last Name _____

Patient's Date of Birth _____ Your Relationship to the patient _____

When do you believe that the violation of health information privacy rights occurred?
List Date(s), *(include clinic visit dates if appropriate)* _____

Describe briefly how and why you believe a privacy violation occurred. *(Please attach additional pages if necessary)*

Please sign and date

Signature _____ Date _____

Please Return the completed form to: Southwestern Medical Center
Attn: Privacy Officer
5323 Harry Hines Boulevard
Dallas, TX 75390-8851
FAX (214) 648-4306