COMMUNITY HEALTH ALLIANCE

HIPAA COMPLAINT FORM

Today’s Date: ________________

All information can be submitted anonymously, any identifying information is not required.

<table>
<thead>
<tr>
<th>Full Name (Optional):</th>
<th>Health Care Record #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone Number:</td>
</tr>
</tbody>
</table>

If you are filing a complaint on someone’s behalf, provide the name and address of the person on whose behalf you are filing.

Name: ____________________________________________________________

Address: _________________________________________________________

Please describe in detail the nature of your complaint, including the date or dates of the incident(s), and the name or names of any Community Health Alliance staff member(s) and other witnesses (attach additional sheets if necessary):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Patient or Personal Representative’s Signature: __________________________

Date: __________________

Relationship (if not the Patient): ________________________________

Send to: Community Health Alliance
Privacy Officer, 680 S. Rock Blvd.
Reno, NV  89502
Fax: (775) 870-4612

CHA Use Only:
Manager’s acknowledgement of receipt: Print Name: __________________________ Date: ___________

Process of Investigation:

Formal Action Taken/Resolution:

Director/Compliance Officer Comments:

Director/Compliance Officer Signature: ______________________________ Date: ___________

Place in HIPAA Log Binder, if HIPAA related. Otherwise, place in Risk Management file.