COMMUNITY HEALTH ALLIANCE

COMMUNITY HEALTH ALLIANCE
HIPAA COMPLAINT FORM

Today's Date: _____

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

Full Name (Optional):	Health Care Record #:
Address:	Phone Number:

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.