

**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 14<sup>th</sup> 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**

NAME: \_\_\_\_\_  
 MRN: \_\_\_\_\_  
 LAST 4 DIGITS OF SSN: \_\_\_\_\_  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 DATE: \_\_\_\_\_ TIME: \_\_\_\_\_



Form  
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6/10/11