

**Attachment 44**

Effective Date: April 14, 2003

**Complaint Form**

Any person has the right to file a complaint if the person believes that a University of Miami provider 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 Privacy Office. It may be personally delivered to the University of Miami Privacy Office located in the Professional Arts Center Building at 1150 NW 14<sup>th</sup> Street or it may be sent via US Mail to the address below.

This complaint will apply to the department/office you list below. **Please provide the following information:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Soc. Sec. Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_  IDX  SMS

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of person

\_\_\_\_\_  
Date

University of Miami Privacy Office PO BOX 019132 (M-879) Miami, FL 33101	privacy@med.miami.edu (305) 243-5000
<b>Complaint Form</b>	
Form D3900042E  Revised 10/10/03	



NAME: \_\_\_\_\_

MRN: \_\_\_\_\_  IDX  SMS

SS: \_\_\_\_\_

AGE: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE OF SERVICE: \_\_\_\_/\_\_\_\_/\_\_\_\_