



Excellence is our only standard

PRIVACY COMPLAINT REPORT FORM

PATIENT NAME: _____

MAILING ADDRESS: _____

City _____ State _____ Zip _____

TELEPHONE: () ()
Daytime Cell

Email Address: (Optional) _____

PERSON REPORTING THE COMPLAINT: ___ Patient ___ Family Member ___ Other

*Are you filing the complaint on behalf of another individual? ___ Yes ___ No

(If yes, please provide the following information)

Table with 2 columns: NAME OF PERSON REPORTING (Last Name, First Name, MI) and Relationship to the patient (i.e., spouse, friend, etc.). Includes fields for Address, City, State, Zip, Telephone, Cell, and Email.

1. Where did the incident occur? (please identify the facility, department, or service area Ephraim McDowell Health)

2. When did the incident occur? If the exact date(s) is unknown, please provide an approximate timeframe.

3. How did you become aware of the incident?

4. What type of HIPAA violation do you believe may have occurred? Select all that apply.
___ Unauthorized access or viewing of Protected Health Information
___ Unauthorized disclosure of Protected Health Information
___ Loss of health information records
___ Failure to respond to a request to access personal health information or receive a copy of a requested medical record
___ Other (please explain)

5. Do you wish to report a complaint regarding the policies and procedures established by Ephraim McDowell Health to safeguard PHI without alleging a potential violation of your privacy rights? ___ Yes ___ No
(If yes, please describe your concern under the Complaint Description on page 2)

INTERNAL USE ONLY:
Complaint Received by: _____
Name Title
Date Complaint Received: _____ Time Received: _____
Complaint Received: ___ In Person ___ By Telephone ___ Mail (please attach) ___ E-mail (please attach)

Submit this completed form to the Privacy Officer at 217 South Third Street, Danville, KY 40422
(859) 239-2339 Voice (859) 239-6755 Facsimile (dedicated line) E-mail: privacyofficer@emhealth.org

