UT Southwestern Medical Center

PRIVACY COMPLAINT FORM

For Patient Use Only

For Internal Use Only

Tracking Number _____

If you have questions about completing this form, please call 214-648-6080 and leave a message.

Date _____

Your First Name _____ Your Last Name _____

Home Phone (_____) _____ Work Phone (_____) _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Date of Birth _____

Are you filing this complaint for someone else? ☐ Yes ☐ No (*if No, go to next section)*
If *Yes*, whose health information privacy rights do you believe were violated?

Patient's First Name _____ Patient's Last Name _____

Patient's Date of Birth _____ Your Relationship to the patient _____

When do you believe that the violation of health information privacy rights occurred?

List Date(s), (include *clinic visit dates if appropriate)* _____

Describe briefly how and why you believe a privacy violation occurred. *(Please attach additional pages if necessary.)*

_____

_____

_____

_____

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_____

_____

_____

Please sign and date

Signature _____ Date _____

Please return the completed form to:

UT Southwestern Medical Center
Attn: Privacy Officer
5323 Harry Hines Boulevard
Dallas, Texas 75390-8851
FAX (214) 648-4306

Form # OCA/PCF-001 / 07.12
(Reviewed 09/13)