

HIPAA Privacy Complaint Form

To submit a complaint, please complete this form and return to the address listed below.

Last Name: _____ First Name: _____ MI: _____

Mailing Address (Street or PO Box): _____ City: _____

State: _____ Zip: _____ Daytime Phone: _____ Home Office Cell

If we cannot reach you directly, is there someone else we can contact to help us reach you?

Name: _____ Daytime Phone: _____

Are you filing this complaint for someone else? Yes No

If yes, whose health information privacy rights do you believe were violated?

Last Name: _____ First Name: _____

Name of the person and/or facility you believe violated your (or someone else's) health information privacy rights or committed another violation of the HIPAA Privacy Rule?

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

Briefly describe what happened. How and why do you believe your (or someone else's) health information privacy rights were violated or the HIPAA Privacy Rule was violated? Please be as specific as possible.

Signature: _____ Date: _____

Save this form and email to compliance@wmed.org
or print and mail to:
Williamson Medical Center
Administration
4321 Carothers Parkway
Franklin, TN 37067



4321 CAROTHERS PARKWAY • FRANKLIN
williamsonmedicalcenter.org