



# West Virginia University Physicians of Charleston

## Health Information Privacy Complaint Form

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Please describe the nature of the complaint: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Attach additional page if needed)

Date of Occurrence: \_\_\_\_\_

Please list possible recipients of the protected health information:

Name

Organization:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

*Please mail this form to the following address: Susan B. Saxe, Esq., Privacy Officer, WVU Physicians of Charleston, 3110 MacCorkle Avenue, S.E., Charleston, West Virginia 25304*