WVU 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