Guadalupe Regional MEDICAL CENTER

HEALTH INFORMATION PRIVACY / HIPAA COMPLAINT FORM

Any individual has the right to file a complaint if the individual believes that Guadalupe Regional Medical Center did not adequately protect the health information entrusted to us. The complaint must be filed in writing within 180 days of the event. Filing a complaint will not affect the treatments or services you receive from Guadalupe Regional Medical Center. To file a complaint, please complete this form and return to the address or email listed below:

Guadalupe Regional Medical Center
Compliance/HIPAA Officer
1215 E. Court Street
Seguin, TX 78155
hipaa@grmedcenter.com

The information you provide here will remain confidential to the extent possible, however as a complainant, you understand that during the course of the investigation it may become necessary for Guadalupe Regional Medical Center to reveal your identity or identifying information about yourself to the person(s) at our hospital under investigation or to other persons, agencies, or entities.

YOUR INFORMATION		
YOUR FIRST NAME		YOUR LAST NAME
HOME PHONE (Please include area code)		WORK PHONE (Please include are code)
STREET ADDRESS		CITY
STATE	ZIP	EMAIL ADDRESS (If Available)

CONSENT TO DISCLOSE YOUR NAME (Please check only one box)

Please select one of the following options:

☐ **Consent Granted**. I consent and give permission to Guadalupe Regional Medical Center to reveal my identity or identifying information about me in my case file to person(s) at the hospital under investigation or to other relevant persons, agencies, or entities during any part of this investigation or enforcement process.

☐ **Consent Denied**. I do not consent or give permission to Guadalupe Regional Medical Center to reveal my identity or identifying information. I understand that this denial of consent will likely limit or delay the hospital's ability to investigate this complaint and **may result** in closure of the investigation.

COMPLAINT FORM (Continued on next page)

INFORMATION ABOUT YOUR COMPLAINT

Who do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

INDIVIDUAL'S NAME

When do you believe that the violation of the health information privacy rights occurred? LIST DATE(S)

Briefly describe what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed).

Please sign and date this complaint. You do not need to sign this form if submitted by email because submission by email represents your signature.

SIGNATURE	DATE (mm/dd/yyyy)

For Guadalupe Regional Medical Center personnel only

Date of receipt of complaint: