Complaint Data Collection Form

☐ Open ☐ Closed

____
Today's Date

____
Name of Person Reporting Incident

____
Relationship to Patient
(self, husband, sister, etc.)

____
Name of Patient

Phone: (h) ______________________
(w) ______________________
(cell) ______________________

Medical Record #: ______________________
~ OR ~
Account #: ______________________

Date of Incident:
Begin: ______________
End: ______________

Method of Receipt:
(phone, staff referral, walk-in)
____

☐ Risk Management ☐ HIPAA Risk ☐ Employee Sanctions

Feedback Category: (check one)

☐ Failure to Release
☐ Environmental
☐ Law Enforcement
☐ Data Integrity
☐ Inappropriate Release
☐ General Privacy
☐ PIN
☐ Identity Theft
☐ NOK/POA
☐ Right to Amend/Copy/Restrict
☐ Billing

Time Allocation: ☐ Simple ☐ Average ☐ Complex

Description of Complaint: ☐ See attached.

____
____
____
____
____
____
____
____
____
____

Activity: ____
____
____

Resolution:

Investigation: