Privacy Complaint Form

Date: _____

Patient/Individual

First Name | Middle Initial | Last Name | Date of Birth

Phone Number (with area code) | Email Address (optional)

Relationship to Patient:

Complaint

Please share details regarding your privacy complaint, including locations, dates, and parties involved.

Review and Sign

I acknowledge that I have read all of the information on this form.

Signature of Individual or Individual's Legally Authorized Representative **Date**

X_____ _____

Your Right to File a Privacy Complaint

- **You have a right to receive information about how to file a complaint about the privacy of your personal health information.**
- **You have a right to receive the Colorado Physician Partners "Notice of Privacy Practices", which tells you how your personal health information will be used and disclosed. The Notice of Privacy Practices also tells you how to file a privacy complaint.**
- **You may choose a representative to represent your interests during the complaint process.**
- **Your services will not be affected by any complaints you make.**
- **Colorado Physician Partners cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful.**

Please send this completed form by mail or email to:

Attn: Privacy Officer
Physician Health Partners
PO Box 13406
Denver, CO 80202-9998

Privacy@Alpine-Physicians.com