Complaint Report Form

University of Wisconsin-Milwaukee
[Covered Department Name and Contact Information]

Patient Name (print): _____

Date of Birth: _____

Person Reporting: _____

Relationship to Patient: _____

Telephone Number: _____

Nature of Complaint: _____

_____

_____

_____

_____

_____

_____

_____

_____ [attach any additional information]

Possible Recipients of Protected Health Information:

Name	Organization
_____	_____
_____	_____
_____	_____

If completed by the patient or patient's representative, please mail this form to:

[Name of Privacy Officer]
Privacy Officer, [Name of Covered Department]
University of Wisconsin—Milwaukee
P.O. Box ____
Milwaukee, Wisconsin 53201

* * * * * *

For internal use:

Date Complaint Received _____

Complaint Received By _____