PHYSICIANS INDEPENDENT MANAGEMENT SERVICES, INC.
REQUEST TO FILE A COMPLAINT

Purpose: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we protect the privacy of your health information and that we notify you of the ways we use and disclose that information to other people. You also have a right to complain, in writing, about situations in which you believe we, or other organizations that work for us, have not met our responsibility to protect your health information. Our physicians and staff will not discriminate or retaliate against you because of this complaint.

Please provide us with as much detail as you can so that we can fully investigate this event and make sure we improve the way we protect your health information. You will be contacted after we have performed and reviewed our investigation.

Please complete all sections below.

Name _____ Email Address _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____

What is the best way to reach you? _____

What are the best hours to reach you? _____

Details of your complaint. (Please be as specific as possible with dates, times and the specific policy, procedure or action taken. Include the names, if any, of anyone whom you discussed this. Use additional pages, as needed.

Names of those involved.	
Complaint	

Signature _____ Date of Complaint _____