Patient Privacy Complaint Form

Patient Name ____ Date of Birth ____________________

Address ____

City/State/Zip____

Telephone _______________________________ Fax Number ___________________________________
(Include area code) (Include area code)

Please describe the nature of your complaint:

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Name of Patient or
Personal Representative *(PLEASE PRINT)*____

Signature of Patient or
Personal Representative: ____ Date: ________________
(If Personal Representative, include a description of authority to act for patient)

Please submit this form directly to:

GCRMC Form# HIPAA8 5-12

Privacy Officer
Gerald Champion Regional Medical Center
2669 North Scenic Drive
Alamogordo, NM 88310
If you have any questions, please contact the Privacy Officer directly at 575-443-7857

For GCRMC Use Only

Date Received _________________________________

Date Response Provided to Patient ____

Signature of Employee____ Date ________________

Print Employee Name & Title____

Patient Identification

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