HIPAA COMPLAINT REPORT

Your Name:	
Address:	
Telephone Number:	
E-mail Address:	Date:
are filing.	the name and address of the person on whose behalf you
Name:	
Address:	
Information about Suspected Privacy Viola	tion:
Please describe in full detail the nature of your privacy cor the name or names of any MAK Anesthesia personnel invo necessary):	•
Patient or Legal Representatives' Signature	 Date
Relationship (if not patient)	
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To file a complaint with the Office for Civil Rights, access: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Send to:

MAK Anesthesia Providers, LLC Attn: HIPAA Privacy and Security Officer 1300 Ridenour Blvd NW

Suite 300

Kennesaw, GA 30152

Or Email: hipaa-privacy@makanesthesia.com

For Internal Use Only:

Privacy Officer's acknowledgement of receipt: _		
Compliant was delivered by: (Circle One)	Personal delivery	Regular Mail
	E-mail	Voice-mail
Date Received//	Time Received	: a.m. / p.m.
Communicated to HIPAA Privacy and Security C	officer by(print nam	e here)
HIPAA Privacy and Security Officer acknowledge	• • • • • • • • • • • • • • • • • • • •	ın/initial here)
Date Received:/	, 5	:a.m. / p.m.
Process of investigation:		
Formal action taken/resolution:		
HIPAA Privacy and Security Officers Signature	/_ Date	J
Comments by the HIPAA Privacy and Security O		