

**Adams County Memorial Hospital and its Divisions
P.O. Box 151, Decatur, IN 46733 (260) 724-2145**

Privacy Complaint Form

1. Date of this complaint: _____
2. Date(s) that you believe this breach of confidentiality or violation of privacy rights occurred:

3. Location of breach or violation: _____
4. Name of person whose confidentiality was breached and/or whose privacy rights were violated:

5. Name of person completing this form, if other than the person named above, and the relationship:

6. Briefly describe what you believe happened and why this constitutes a breach of confidentiality or a violation of privacy rights: _____

7. How did you become aware of this breach or violation?

8. Who, if anyone, do you think may have been responsible for this breach or violation?

9. What harm do you believe may have been caused by this breach or violation?

10. What do you feel can be done to lessen any harm that may have occurred as a result of the breach or violation? _____

11. Other comments: _____

12. Phone number where someone can contact you to discuss your concerns: _____

Signature

Date

Printed Name