



National Naval Medical Center-Bethesda HIPAA Patient Complaint Form

Today's Date: _____

Name: _____

(If same as beneficiary please skip next blank)

Beneficiary's Name: _____

Address: _____

Phone/Email: _____

Date of Occurrence: _____

Place of Occurrence: _____

Concern(s) *(How was the patient's protected health information (PHI) violated?)*: _____

Submitted By: _____

Name: _____ Location: _____

Contact Number: _____

Signed: _____ Department: _____

Return this form to:

HIPAA Privacy Office
Attn.: Joe Davidge
National Naval Medical Center
8901 Wisconsin Avenue
Building 1, Deck 7 (7th Floor), Room 7141
Bethesda, Maryland 20089-5600
Phone: (301) 319-4775
Email: – NNMC-HIPAA@bethesda.med.navy.mil

Action Taken *(For Internal Use Only)*: _____

