



HIPAA COMPLIANCE COMPLAINT FORM

Participant Name: _____ Social Security Number: _____

Address: _____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____ Participant Birth Date: _____

I would like to file a complaint about the privacy practices and/or procedures at the MPI Health Plan. The following is my statement: *(Please include specific details such as specific personnel involved and the date and location of the event of concern to you.)* (If more space is needed, attach a separate sheet.)

By signing this form, I am confirming that it accurately reflects my wishes.

Participant Signature

____/____/____
Date

If this Complaint is to be signed by a personal representative, that personal representative must also sign below before submitting this form to the MPI Health Plan.

If signed by personal representative, name of personal representative: _____

Relationship to Participant or nature of authority: _____

Signature of Personal Representative

____/____/____
Date

THIS REQUEST MUST BE COMPLETED IN FULL BEFORE BEING SUBMITTED