PRIVACY COMPLAINT

Name: _____ Last 4 SSN: _____

Telephone: _____

Preferred Mailing Address: _____

_____

Are you a Veteran? ____Yes ____No Are you an Employee? ____Yes ____No

Check all that apply:

☐ I request a Sensitive Patient Access Report (SPAR), detailing all entries into my electronic medical record, be generated from_____/___/___to____/___/___and released to me.

____ I believe my record may have been accessed without justification or appropriate authorization from me.

____ Review purposes only. At this time I do not believe my record has been accessed inappropriately. I understand that if the SPAR reveals questionable entries, I must file a new request with the Privacy Office.

____ I believe PHI from my medical record may have been released to a 3rd party without proper authority.

☐ I have another privacy concern. Please describe below.

☐ I would like to schedule a meeting with Privacy Officer to discuss my concerns. The most convenient day/time for me is: _____

To avoid delay, please **explain your concern in detail** (use additional sheets if needed) and attach any supporting documentation. You may hand-deliver to the Privacy Officer, Room # 1B-221, route in a Privacy Envelope to (00P) or fax to (804) 888-9538. **Please print.**

_____

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1. I understand the Privacy Officer, or her designee, may enter my electronic medical record over a period of several weeks in order to adequately research and address my concern. 2. I agree that I will not personally contact individuals listed on the SPAR, nor will I request others contact individuals on my behalf. 3. All statements are true and complete to the best of my knowledge.

_____

Signature date

**Personal representatives must provide copy of properly executed Power of Attorney.* *Rev. 11/28/16*