Privacy Rights Complaint Form

Any person has the right to file a complaint if the person believes that a Stamps Health Services provider has not adequately protected the health information entrusted to us or ensured patient rights with respect to their health information. To file a complaint, you may complete this form and return it to: Privacy Officer, Stamps Health Services, 740 Ferst Drive Atlanta GA 30322.

This request applies only to the health care provider that you list below. If you have privacy concerns about other providers, you must complete a form for each provider. There may be a reasonable fee, based upon our costs, to provide this information. Please provide the following information:

Please provide the following information:

Patient Name: ________________________ Date of Birth: ___________________

GT ID#: ____________________________ Phone number: ___________________

Address:  __________________________________________________________

I am submitting a complaint about (please indicate the health care provider):
____________________________________________________________________
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Please describe the privacy concern.
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____________________________________  ___________
Signature of patient or personal representative             Date

__________________________________________________
If personal representative, authority to act on behalf of patient

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