

**GEORGIA INSTITUTE OF TECHNOLOGY**  
**STAMPS HEALTH SERVICES**

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**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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**FOR INTERNAL USE ONLY**

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Received by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Disposition:

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Notification made:

By: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Method: \_\_\_\_\_