Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You" SM

HEALTH INFORMATION PRIVACY COMPLAINT

Name			Date of Birth
Street Address	City	State	Zip Code
Telephone Number			Cell Number
Date of Request			E-Mail Address: (if available)

Are you filing this complaint for someone? ☐ Yes ☐ No

If yes, whose health information privacy rights do you believe were violated?

FIRST NAME LAST NAME

Who do you believe violated your (or someone else's) health information privacy right or committed another violation of the Privacy Rule?

PERSON/ORGANIZATION			
STREET ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER

When do you believe that the violation of health information privacy rights occurred?
LIST DATE(S)

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (attach additional pages as needed)

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE DATE