Restore Medical Fitness
4545 Transit Rd.
Williamsville, NY 14221
716-906-2102

HIPAA Compliance Office
Maria Kreher

F-1007 HIPAA – Official Complaint

PATIENT INFORMATION

Date

Name (Last, First, Middle initial) | Date of Birth

Street address, City, ST, ZIP Code | Email address

Primary phone number | Other phone number | Fax number

Please provide detailed description of the HIPAA complaint and cause.

Please indicate an acceptable method of contact (Select all that apply)

By selecting this method of contact I am giving Restore Medical Fitness my consent to contact me by the indicated means with applicable updates addressing this complaint.

☐ Mailing Address (as listed above)
☐ Email (as listed above)
☐ Primary Phone (as listed above)
☐ Other Phone (as listed above)

Do you authorize Restore Medical Fitness to leave a phone message?

☐ Yes ☐ No

Please list Restore Medical Fitness staff member that was contacted regarding this matter:

Name of Restore Medical Fitness staff member | Date

Patient (or legal health representative) Signature | Date

(Attach additional documentation, if applicable.)

For Administrative Use Only:

Date received

Action taken

Date

Action taken

Date

HIPAA Compliance Officer Signature

Date