

**ZIMBRICK, INC
PRIVACY COMPLAINT FORM**

Plan Member Name:

Plan Member Address:

Today's Date:

Date acts or omissions are believed to have occurred:

Description of the acts or omissions believed to be in violation of privacy:

Please describe the Protected Health Information (PHI) affected:

Do you know of anyone who may have received the PHI? YES _____ NO _____

If so, please specify the name and address of the organization or individual:

Signature of Plan Member:

Date:

FOR PRIVACY OFFICER USE ONLY

No Violation Occurred

Possible Violation and Remedial
Action Needed

Changes need to be made
to existing DORs

New DORs need to
be created

Date Received by Privacy Officer