HIPAA COMPLAINT FORM

INCIDENT DATE: _____ **DATE FILED: _____**

INCIDENT OCCURRED:_____

COMPLAINT AGAINST: _____

WITNESSED BY: _____

DESCRIBE INCIDENT IN DETAIL: (Or attach other documentation.)

DEPARTMENT OF THE ARMY
HEADQUARTERS, TRIPLER ARMY MEDICAL CENTER
1 Jarrett White Road
Tripler AMC, Hawaii 96859-5000

PRIVACY OFFICER FOLLOW UP:

FINDINGS:

- ☐ **SUBSTANTIATED - HIPAA INFRACTION**
- ☐ **UNSUBSTANTIATED – NOT A HIPAA INFRACTION**
- ☐ **PENDING _____**
- ☐ **OTHER _____**

FILED BY: _____
DATE: _____