North Florida Pediatrics

Complaints for Privacy Violations

Our practice takes your privacy seriously. If you feel we have violated your privacy in any way, we want you to fill this form out so we may properly investigate the event.

Print Name: _____ DOB: _____

Address: _____

City, State & Zip Code: _____ Phone: _____

When do you believe the violation occurred? _____

Describe briefly what happened; please be as specific as possible:

What is the best way to contact you? _____

What is the best time to reach you? _____

Please note that no one will retaliate or take any actions against you for filing a complaint.

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature: _____ Date: _____

Relationship to Patient: _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a power of attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____