SOUND INPATIENT PHYSICIANS, INC.
AND ITS AFFILIATED COVERED ENTITIES
PRIVACY COMPLAINT

NAME:_____

ADDRESS:_____

TELEPHONE:_____

If this complaint relates to a specific patient, please fill out the following information:

Patient's Name:_____

Address (if different from above):_____

Patient's Birth Date:_____ Patient's SSN:_____

Telephone (if different from above):_____

DESCRIBE THE NATURE AND DETAILS OF YOUR COMPLAINT. *(Please include specific details such as specific personnel involved and the date and location of the event of concern to you. Attach additional pages if necessary.)*

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WOULD YOU LIKE TO RECEIVE ADDITIONAL COMMUNICATION REGARDING THE RESOLUTION OF THIS ISSUE? _____ YES _____ NO

SIGNATURE:_____ DATE:_____

All complaints must be submitted in writing to:

Julie Seitz, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422