PATIENT HEALTH INFORMATION COMPLAINT REGISTRATION FORM

TO BE COMPLETED BY PERSON REPORTING A COMPLAINT DATE: _____

DATE OF SERVICE: _____ LOCATION OF SERVICE: _____ TIME OF INCIDENT: _____

PATIENT NAME: _____ TELEPHONE # :_____*

PERSON REGISTERING COMPLAINT: _____ TELEPHONE # :_____*

*** A REPRESENTATIVE FROM MIDSTATE WILL CONTACT YOU FOR FURTHER INFORMATION**

NATURE OF COMPLAINT: _____

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