## PATIENT PRIVACY COMPLAINT REPORT FORM

## New River Family Wellness, PLLC 420 East Second Street, West Jefferson, NC 28694

Patient Name:	Telephone #:
Address:	
If person reporting is other than patient above:	
Name:	Telephone #:
Relationship to patient:	
Address:	
Please Describe the incident:	

	FOR OFFI	ICE USE ONL	Y		
Date Received:	Time Recei	Time Received:		d by:	
Report Received:	In Person		Mail (pl	please attach)	
Summary of Investigation:					
RESPONSE					
Respondent:	Date	:	Time:		
Method of Response:	In Person			Mail	
Detail of Response:					
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