HIPAA Complaint Form

What is the purpose of this Form?

This form allows you to submit a complaint if you feel that your Protected Health Information ("PHI") was unlawfully used or disclosed in violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in a Walmart or Sam's Club Pharmacy, Vision Center/Optical, or Optometrist location (collectively "Walmart") or if you have a complaint about Walmart's HIPAA policies or procedures. Walmart will respond to your complaint within a reasonable time. Walmart will not intimidate, threaten, coerce, discriminate, or take other retaliatory action against you for the exercise of your HIPAA rights or making HIPAA complaints.

Section 1: Patient Information

Patient Name (last, first, middle initial):		Date of Birth (mm/dd/yyyy):	
Address:			
City:	State:	Zip:	Phone:

Section 2: Complaint Section

(a) □ Pharmacy □ Vision Center/Optical □ Walmart/Sam's Club Optometrist

_____ City and State

_____ Store Number

(b) **Details of your complaint:** *Please be as specific as possible with patient names, dates, times, and the specific policy, procedure or action taken (include names of anyone in the Pharmacy, Vision Center/Optical, or Walmart/Sam's Club Optometrist location with whom you have discussed this complaint. Attach any relevant documents. You may use the other side of this form if you need more space):*

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(c) Return this form to any Walmart or Sam's Club Pharmacy, Vision Center/Optical, or Optometrist. You may also mail it to ***Walmart Inc., Attn: HIPAA Privacy, 2608 S.E. J Street, Suite 8, Mailstop 0230, Bentonville, AR 72716-0230.***

Section 3: Signature and Date

_____ Name of Patient or Personal Representative (please print)

_____ Signature of Patient or Personal Representative

_____ Date

If you have signed this form as a legally authorized representative of the patient, please identify your relationship to the patient: (parent, guardian, etc.) _____

For Store/Club Use Only

Store/Club Number: _____ □ Sent to HIPAA Privacy

_____ Date

_____ Associate

Send completed form to HIPAA Privacy. See POM/VCOG 1619.