Hazel Health

Patient Complaint and Grievance Form

Hazel Health is committed to the privacy of our patients' personal health information, and providing quality patient care and promoting patient/family satisfaction.

We take all complaints seriously. To submit a complaint in writing, please complete this form and send it to Hazel Health's Compliance Department at compliance_report@hazel.co or via mail using the address at the bottom of this form.

Submission Date: _____

Service Type:

- Physical health
- Mental Health
- Both

Patient Information

Patient's Name	
Date of Birth	
Address	
Phone Number	
Email	
Person Filing Complaint	
Relationship to Patient	

Complaint Type (please select all that apply)

- HIPAA Violation
- Quality of Care
- Customer Service
- Billing
- Other _____

Date of Occurrence/Date of Service:_____

Hazel Health

Please describe what happened. Be sure to include specific dates, times, people's and providers' names, places, etc. that were involved. Please send copies of anything that may help us understand your grievance to compliance_report@hazel.co:

Have you tried to resolve the issue, and what would you consider to be a proper solution to the issue?

Acknowledgements

I certify that the information on this form is true and correct to the best of my information, knowledge, and belief. I also acknowledge the following non-retaliation statement from Hazel Health:

Hazel Health will not retaliate or take any adverse action against any person who honestly and in good faith:

- Raises a concern regarding the company,
- Identifies, escalates, or reports a compliance incident or violation,
- Opposes an act or practice that the person believes to violate a law
- Participates in an investigation, or
- Exercises any rights provided by HIPAA

Hazel Health

Signature of Patient/Legal Guardian/Authorized Representative Date

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Hazel Health Mailing Address:

ATTN: <COMMITTEE TBA>
8300 Esters Blvd, Suite 900
Irving, TX 75063

This section to be used for internal use only:
Reviewed by (print name and title): _____Date: _____
Referred to: _____Date: _____
Resolution:_____

_____

_____

_____

_____**Corrective Action Completed? ☐ Yes ☐ Not needed Patient Contacted? ☐ Yes ☐ No Returned to Department Director:_____Date: _____**