

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 Care Clinic (collectively “Walmart”). 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-related 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 Care Clinic _____
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 Care Clinic 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.*

(c) Return this form to any Walmart or Sam’s Club Pharmacy or Vision Center/Optical, or mail it to **Wal-Mart Stores, Inc., Attn: HIPAA Privacy, 702 SW 8th St., Mailstop 0230, Bentonville, AR 72716.**

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 below.
(parent, guardian, etc. _____)

For Office Use Only

Store/Club Number: _____ Complaint Status: Responded To _____
Date Associate

Email this form to the HIPAA Team Inbox at HIPAARx@Wal-Mart.com



Patient Privacy. Our Priority!

