

**Saint Luke's Health System**  
**HIPAA Privacy and Security Complaint Form**

Please mail to: Saint Luke's Health System  
ATTN: System Privacy Officer  
901 E. 104<sup>th</sup> St. – Mailstop 3000-S  
Kansas City, MO 64131

You may also fax this form to 816-932-6846  
ATTN: System Privacy Officer

**Complainant Information (Please Print):**

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_  
(If different from above)

Patient Date of Birth: \_\_\_\_\_ Name and Relationship to patient: \_\_\_\_\_  
(if applicable)

**Complaint Information:**

Facility Involved:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Anderson County   | <input type="checkbox"/> Crittenton Children's Center                      | <input type="checkbox"/> Hedrick Medical Center | <input type="checkbox"/> Saint Luke's Cushing |
| <input type="checkbox"/> Saint Luke's East | <input type="checkbox"/> Saint Luke's Hospital                             | <input type="checkbox"/> Saint Luke's North     | <input type="checkbox"/> Saint Luke's South   |
| <input type="checkbox"/> Wright Memorial   | <input type="checkbox"/> Other - Clinic or facility (indicate name): _____ |   |   |

Date of Incident: \_\_\_\_\_

Complaint: (Please attach additional page(s) if necessary)

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Signature of Patient/Complainant: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Not a Part of the Permanent Medical Record**

