



PRIVACY AND DATA SECURITY FORM

Today's Date: _____

Beth Israel Deaconess Hospital-Plymouth, Inc. strives to protect the privacy and security of patient protected health information and employee personal information in accordance with all Federal and State laws and regulations. If for any reason, you feel that your medical or personal information has or may have been compromised, we ask you to complete this form immediately. Be sure to provide enough information so that we may understand the full scope of your concern, the information and people who are or who may have been involved, and the date/time of the incident. (Attach additional pages if needed). A member of our Office of Compliance and Business Conduct Department or the Chief Information Security Officer will review the matter and make all reasonable efforts to resolve it.

1. May we contact you if we need additional information in investigating your concern? Yes No
2. Would you like us to contact you with the results of our investigation? Yes No
3. Are there any documents available that we should look at or obtain, for additional information regarding your concern? If yes, please provide a description and location of each document.

4. Please describe what you see as an acceptable resolution/outcome to this complaint. Please know we cannot guarantee your suggested outcome but sincerely appreciate your input.

Patient Name: _____

Patient DOB: _____

Patient Address: _____

Your Name: _____

Your Telephone #: _____

Your Address: _____

We value all feedback from patients, families, visitors, and employees so that we may better serve you. Please return this form to: **Beth Israel Deaconess Hospital-Plymouth, Attn: Office of Compliance and Business Conduct, 275 Sandwich Street, Plymouth, MA 02360.**