SALUS

# GRIEVANCE FORM

Purpose: This form will be used by individuals to file their grievances regarding our compliance with privacy practices.

**SECTION A: Information on the person filing the grievance.**

Name: _____

Address: _____

Phone Number: _____ Email: _____

Policy Number: _____ Social Security Number: _____

**NOTE TO CLAIMANT: Please read and complete all the information required below.**

You are entitled to submit a grievance regarding the way we comply with our own policies or with federal or local privacy policies or laws. We will investigate your grievance and respond in writing within 30 business days. We do not expect you to waive your rights under federal or local privacy laws. You grievance will not affect the treatment you receive at the clinic. SALUS will take no reprisal whatsoever against your for filing a grievance. To exercise your right, please complete Sections A and B below, sign the document, and send it to:

Contact Office: OFICINA DE PRIVACIDAD DE SALUS

Phone: (787) 749-4045 Email: dallende@ssspr.com

Address: PMB 509, PO Box 7891, Guaynabo, PR 00970-7891

If you have questions or concerns, or need help to complete your grievance form, please contact us at the specified address.

**SECTION B: Your Grievance.**

Provide a brief explanation of your grievance:

_____

_____

_____

_____

Provide a brief explanation of the results you expect as a result of your grievance:

**YOUR SIGNATURE**

Signature: _____ Date: _____

If this grievance is filed by a personal representative appointed by the insured person, please provide the following information:

Name of Personal Representative: _____

Relationship to Claimant: _____

**YOU ARE ENTITLED TO RECEIVE A COPY OF THIS GRIEVANCE FORM**