MEDICINE

Patient Grievance Form

Use this form to let us know about a complaint or concern ("grievance") you have about your experience.

You may bring the form to your clinic and provide it to the front desk, email a copy to chs.privacy@okstate.edu or mail it to 2345 Southwest Blvd, Suite 250, Tulsa, Oklahoma 74137.

Patient name: _____

Date of birth: _____ Today's date: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____ OK to leave a message for you at this number? ☐Yes ☐ No

Tell us about your complaint/concern:

Clinic/location:

☐ OBGYN	☐ Surgery	☐ Cardiology	☐ Addiction	☐ Radiology
☐ IM/IMSS	☐ Neurology	☐ Behavioral Health	☐ Billing	☐ Biomedical Imaging
☐ Pediatrics	☐ Family Medicine	☐ Other: _____		

Please be as specific as possible. Include dates, times, staff names, and locations. Use the other side of the form if needed.

What solution would you like?

Call Back Requested? ☐ Yes ☐ No