MEDICINE

## PATIENT GRIEVANCE FORM

Use this form to let us know about a complaint or concern ("grievance") you have about your experience at one of the OSU Medicine Clinics listed below. We assure you that any grievance filed will not affect your care at OSU Medicine and will be protected by HIPAA privacy laws.

You may bring the completed form to your clinic and provide it to the front desk, or 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:**____/____/____

**Address:**_____ **City:** _____**State**: _____**Zip:** _____

**Contact Name if other than patient:**_____**Relationship to patient:** _____

**Daytime Phone:** _____**Is it okay to leave a voicemail for you at this number?** Yes ◉ No ○

**Clinic and location:**

- ☐ Addiction Recovery
- ☐ Behavioral Medicine
- ☐ Biomedical Imaging
- ☐ Cardiovascular Medicine
- ☐ Family Medicine
  Location: _____
- ☐ Internal Medicine
- ☐ Internal Medicine Specialty Services
- ☐ Neurology
- ☐ Obstetrics & Gynecology
- ☐ Osteopathic Medicine
- ☐ Pediatrics
- ☐ Radiology
- ☐ Surgery
- ☐ Health Access Network
- ☐ Billing
- ☐ Other: _____

**Tell us about your complaint or concern.**
Be specific to include dates, times, locations, and staff names. Use the other side of the form if needed.

_____

_____

_____

_____

_____

**What solution would you like?**

_____

_____

_____

_____

_____

Callback requested? Yes ○ No ○

After reviewing your grievance, you will be contacted to explain next steps.

**Patient or representative signature:**_____ **Date completed:**____/____/____