



### Individual Complaint Form

Individual Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_  
*(include area code)* *(include area code)*

Describe the nature of your complaint:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Individual or  
Personal Representative *(PLEASE PRINT)* \_\_\_\_\_

Signature of Individual or  
Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
*(If Personal Representative, include a description of authority to act for individual)*

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Please submit this form directly to:**

Privacy Officer  
Matria Healthcare, Inc.  
1850 Parkway Place Suite 1200  
Marietta, GA 30067  
Fax Number: 770-767-4588

If you have any questions, please contact the Privacy Officer directly at 770-767-8191

**FOR MATRIA USE ONLY**

Date Received \_\_\_\_\_

Date Response Provided to Individual  
\_\_\_\_\_

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

Print Employee Name & Title \_\_\_\_\_