



Patient Complaint Form

Patient Name _____

Date of Birth _____

Address _____

City/State/Zip _____

Telephone _____ Fax Number _____
(include area code) *(include area code)*

Describe the nature of your complaint:

Name of Patient or
Personal Representative *(PLEASE PRINT)* _____

Signature of Patient or
Personal Representative: _____ Date: _____
(If Personal Representative, include a description of authority to act for patient)

Signature of Witness: _____ Date: _____

Please submit this form directly to: Alere Privacy Officer
3200 Windy Hill Rd, Suite B-100
Atlanta, GA 30339
Or via fax: 770-767-7538

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

FOR ALERE USE ONLY

Date Received _____

Date Response Provided to Patient _____

Signature of Employee _____ Date _____

Print Employee Name & Title _____