



Patient Grievance Form

Hazel Pittman Center patients have the right to raise concerns or file a grievance without retaliation or barriers to services. You may ask a staff member, advocate, family member, legal representative, or another person of your choosing to assist you. Use of this form is encouraged but is not required to file a grievance.

Patient Name: _____

Date Submitted: _____

Person assisting you, if any: _____

Contact information, if you would like us to contact you at a particular number/address:

Please describe your concern or grievance.

Include what happened, when it happened, who was involved, and any other information you think is important.

Have you already spoken with someone at Hazel Pittman Center about this concern?

☐ No

☐ Yes – If yes, with whom? _____

What would you like Hazel Pittman Center to do to address your concern?

Patient Signature: _____

Date: _____

Person Assisting, if applicable: _____

Date: _____

For Agency Use

Date Received: _____

Received By: _____

Forward to: ☐ Treatment Director

☐ Executive Director

☐ Board Chair

Date Forwarded: _____

Written Response Due: _____

Written Response Provided: _____

Further Review Requested: ☐ No

☐ Yes

Final Resolution Date: _____