



## **Client Rights Formal Grievance**

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Marshfield Clinic Health System (MCHS) values the opportunity to learn from patients and address grievances. This form is used to file a formal grievance with MCHS for care received in behavioral health or substance abuse clinics.

Name of patient \_\_\_\_\_ Date of birth (m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If you are not the patient, your name and relationship to patient \_\_\_\_\_

Form completion date (m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Reason(s) for grievance(s): \_\_\_\_\_

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

Right(s) potentially violated:  Treatment rights     Record privacy and access     Communication     Personal  
 Privacy     Miscellaneous     Unknown/Unsure

*\*Full list of client rights can be found at <https://www.dhs.wisconsin.gov/clientrights/intro.htm>*

Additional information relevant to this grievance: \_\_\_\_\_

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

Relief/Resolution sought: \_\_\_\_\_

\_\_\_\_\_

### **Signature of patient or person filing grievance on patient's behalf**

Signature/Title \_\_\_\_\_ Date (m/d/y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time \_\_\_\_\_

**Note:** *Grievances are not required to be written. Grievances can be submitted to the Client Rights Specialist orally. If grievances are communicated orally, the grievant should inform the Client Rights Specialist that it is the grievant's intent to file orally.*

### **Send completed form to:**

Patient Experience Liaison  
Marshfield Clinic Health System  
1000 N. Oak Avenue  
Marshfield, WI 54449

**Email to:** Pt.exp.liaison@marshfieldclinic.org

**Or call the patient experience team:** 715-387-5300