COUNTY OF TUOLUMNE

PROTECTED HEALTH INFORMATION (PHI)
PRIVACY COMPLAINT FILING FORM

	DATE:	FILE NUMBER:

The information you provide here will remain confidential to the extent possible. We may need to divulge the information to investigate your claim.

- You may file a complaint without letting us know your name. If you choose to file without using your name, go directly to Section 4.
- Anyone may file a complaint.
- Members of the workforce may use this form to report violations of the Privacy Rule by others in the workforce.

You may submit your complaint to:

Privacy Officer
County of Tuolumne
Human Resources/Risk Management
2 South Green Street
Sonora, CA 95370
(209) 533-6636

1. YOUR INFORMATION

LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:	BEST WAY TO REACH YOU:	BEST HOURS TO REACH YOU:
EMPLOYEES ONLY	**EMPLOYEES MAY FILE COMPLAINTS ANONYMOUSLY**	UNIT TITLE:	SUPERVISOR'S NAME:

2. REPRESENTATIVE INFORMATION
(Complete only if you want us to give your information to someone else.)

I authorize the following person to act on my behalf and to receive any information pertaining to me, as necessary to investigate this complaint.

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
RELATIONSHIP:		
ADDRESS	CITY/STATE:	ZIP CODE:

DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:	BEST WAY TO REACH YOU:	BEST HOURS TO REACH YOU:

3. CONSENT TO DISCLOSE YOUR NAME

Please select one of the following:

☐ I consent to my name being disclosed to the_____(organization) to investigate this complaint.

☐ I do not consent to my name being disclosed to _____(organization). We will not divulge information about you in our investigation within the limits allowed in law. However, not using your name may hinder our ability to complete our investigation.

4. INFORMATION ABOUT YOUR COMPLAINT

NAME OF THE COUNTY DEPARTMENT OR PROGRAM YOUR COMPLAINT RELATES TO:	**NAME OF PERSON YOUR COMPLAINT RELATES TO:**	**DATE YOU FIRST NOTICED ACTION AND DATE(S) ACTION(S) OCCURRED:**

DETAILS OF THE COMPLAINT:

I have reason to believe that one or more of the following has occurred:

☐ The County/person has inappropriately disclosed or released my personal health information.

☐ The County/person has inappropriately used my personal health information.

☐ The County/person has inappropriately disposed of my personal health information.

☐ The County/person has denied access to my personal health information.

☐ The County/person has denied my amendment to my personal health information.

☐ The County's privacy policies and procedures violate HIPAA requirements.

Please provide a detailed description of your privacy complaint covering who, what, when, where, how, and why of what happened. You may attach additional pages if there is not enough space here.

DO YOU HAVE WITNESS(ES): ☐ NO ☐ YES
If yes, please provide the name, address and telephone number of your witness(s) below:

WITNESS NAME	**ADDRESS**	**TELEPHONE NUMBER**
WITNESS NAME	**ADDRESS**	**TELEPHONE NUMBER**

5. RESOLUTION OF YOUR COMPLAINT

PLEASE DESCRIBE HOW YOUR PRIVACY COMPLAINT COULD BE RESOLVED:

6. YOUR SIGNATURE

SIGNATURE:	DATE: