Confidential Report
Health Information Privacy Concern Form

The purpose of this form is to report the facts pertaining to any known or suspected violation of Clark County, Nevada's privacy standards or the laws and regulations governing Clark County.

Although we ask you to provide your name and address, it is not necessary for you to do so if you wish to make an anonymous report. An anonymous report can be made by completing this form and either emailing it to HIPAAPrivacy@umcsn.com; mailing it to Clark County's Privacy Officer, 1800 W. Charleston Blvd., Las Vegas, Nevada 89102 or by placing it in an interoffice envelope addressed to the Privacy Officer, UMC 4th Floor Trauma Building.

Only the Privacy Officer, and others designated by the Privacy Officer, will have access to your report. No disciplinary action or retaliation will be taken against you for making a good faith report of a compliance violation.

Please include all the factual details of the suspected violation, however big or small, to ensure that the Privacy Officer has all of the information necessary to conduct a thorough investigation. Please attach additional pages as needed. The information that you provide should include names, dates, times, places, and a detailed description of the incident that led you to believe that a violation of Clark County's privacy standards occurred. Please include a copy or a description of any documents that support your concerns.

HEALTH INFORMATION PRIVACY CONCERN FORM

YOUR FIRST NAME	YOUR LAST NAME
HOME PHONE *(Please include area code)*	WORK PHONE *(Please include area code)*

STREET ADDRESS		CITY
STATE	ZIP	E-MAIL ADDRESS *(If available)*

Are you filing this concern for someone else? ☐ No ☐ Yes
If Yes, whose health information privacy rights do you believe were violated?
FIRST NAME LAST NAME

Who or what Program do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

PERSON	DEPARTMENT	LOCATION

When do you believe that the violation of health information privacy rights occurred?
LIST DATE(S)

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed)

SIGNATURE	DATE

To mail a concern, please return to the following address:

Clark County Privacy Officer
1800 W. Charleston Blvd., Las Vegas, NV 89102
Tele: (702) 383-3854