



MEDICAL BOARD OF CALIFORNIA Central Complaint Unit



CONSUMER COMPLAINT FORM

Instructions for Filing Your Complaint

- ✓ Fill in the full name, address, telephone number, and license number (if known) of the person your complaint is against. Also write this information in the corresponding section of the Authorization for Release of Medical Information Form on the reverse side of the Complaint Details Form.
- ✓ If the patient has seen another doctor for the **same** problem, include the name, address and date(s) of treatment in the complaint details.
- ✓ Write your complaint and include as many specific details as possible (who, what, when, where, why). Include the date(s) of treatment and specific examples of the problems with the care and treatment, using extra sheets of paper if needed. Send us copies of any documents in support of your complaint which may include patient records, photographs, audiotapes, correspondence, billing statements, proof of payments, etc.
- ✓ Sign and date the complaint form **and** the Authorization for Release of Medical Information Form.

Authorization for Release of Medical Information

The Authorization for Release of Medical Information Form found on the reverse side of the Complaint Details Form is a legal authorization for the Medical Board's staff to obtain information about the patient's care from the doctors and/or medical facilities involved in the medical care. **ANY EXTRA COMMENTS, NOTATIONS, ETC., MAKE THE FORM VOID AND WE WILL HAVE TO ASK YOU TO COMPLETE ANOTHER RELEASE FORM.** If you wish to provide us with additional information, please do so using a separate sheet of paper. If there is more than one physician involved in the patient's care, you may copy the blank form and complete one for each physician and/or facility. When a medical record release form is completed and signed, it allows the Medical Board to order records from **ONLY** the doctors or facilities you have listed on the medical record release form(s).

Print or type the patient's name, date of birth, date of death, and medical record number (if known) in the first section. **FILL IN THE FULL NAME AND ADDRESS OF THE PERSON YOU ARE COMPLAINING ABOUT IN THE NEXT SECTION.** Fill in the names and addresses of all other health care providers where the patient was seen for the medical problems **in this specific complaint** (doctors and/or clinics or hospitals, etc.) using the other medical release forms. If we need to contact you to clarify your information, it will delay the review process.

NOTE: The release form(s) must be signed and dated by **either the patient or the individual legally authorized to make medical decisions for the patient.** If the patient is unable to sign the release, the form may be signed by: 1) the next of kin, if the patient is deceased (provide a copy of the Death Certificate); 2) the parent of a minor child; or 3) the person named by the patient in a signed Power of Attorney granting the person authority to make medical decisions for the patient (provide a copy of this document).