

MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM

Sample

PERSON REGISTERING THE COMPLAINT

Please Print or Type

Mr. Ms.

Name: _____

(Last Name)

(First Name)

(M.I.)

Mailing Address: _____

(City)

(State)

(Zip)

Phone Number: _____

(Daytime Number)

(Evening Number)

(Cell phone/E-mail address)

Mr. Ms.

Patient Name: _____

(Last Name)

(First Name)

(M.I.)

Patient Date of Birth: _____

Your Relationship to Patient: _____

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page

Substandard Care (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)

Prescribing Issues (e.g., excessive/under prescribing, Internet)

Unlicensed Provider or Aiding/Abetting unlicensed practice

Sexual Misconduct

Physician/Provider Impairment
(e.g., Drug, Alcohol, Mental, Physical)

Unprofessional Conduct

(e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)

Office Practice (e.g., Failure to Provide Medical Records to Patient, Failure to Sign Death Certificate, Patient Abandonment)

Other _____

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of State Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Office.



MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____	Date of Birth _____
Medical Record Number (If applicable) _____	Date of Death (If applicable) _____
Control Number _____	Social Security No. (Optional) _____

I, the undersigned hereby authorize:

Physician/Facility _____

Address _____

City/State/Zip Code _____

Phone Number(s) _____

Treatment Date(s) _____

to disclose medical records in the course of my diagnosis and treatment to the **Medical Board of California, Enforcement Program**, a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Medical Board of California at the above address. My written revocation will be effective upon receipt by the Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

Patient Signature _____ Date _____

or Legal Representative _____ Date _____

Relationship _____

NOTE: Failure by a physician, podiatrist or health care provider to provide the requested records within 15 days, or a health care facility in 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.