MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit

CONSUMER COMPLAINT FORM

Instructions for Filing Your Complaint

- ✓ Fill in the full name and address, telephone number, license number (if known) of the person your complaint is against. Also write this information in the first section of the Authorization for Release of Medical Records on the reverse side of the Complaint Detail Form.
- ✓ If the patient has seen another doctor for the **same** problem, include the name, address and date(s) of treatment on the release section of the complaint form.
- ✓ 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 and use 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 at the bottom of the page and on the Authorization Release Form.

Authorization for Release of Medical Information

The Authorization for Release of Medical Information 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 are more than four physicians or medical facilities, you may copy the blank form in order to have enough spaces. When this 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.

Print or **type** the patient's name, date of birth, date of death, and medical record number if applicable. If we need to contact you to clarify your information, it will delay the review process. FILL IN THE FULL NAME AND ADDRESS OF THE PERSON YOU ARE COMPLAINING ABOUT IN THE FIRST 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 sections on the medical release.

NOTE: The release form 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).

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