MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

Enforcement Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2528
Fax: (916) 263-2435
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

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.
- ✓ Pursuant to Business and Professions Code Section 2230.5 the Medical Board must file an Accusation (formal charges) against a doctor's license within three (3) years of the date the Board is first notified of the act or omission alleged as the ground for disciplinary action **or** seven (7) years from the date of the incident, whichever occurs first. Accordingly, please immediately send us copies of any documents that may assist the Board in investigating the allegations. Documents 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).

MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM
Please Print or Type

PERSON REGISTERING THE COMPLAINT

○Mr. ○Ms.

Name: ______________________________
(Last Name) (First Name) (Middle Initial)

Mailing Address: ______________________________
____
(City) (State) (Zip Code)

Phone Number: ______________________________ **Email:** ______________________________
(Daytime Number) (Evening Number)

○Mr. ○Ms.

Patient Name: ______________________________
(Last Name) (First Name) (Middle Initial)

Patient Date of Birth: ______________ **Your Relationship to Patient:** ______________

Signature: ______________________________ **Date:** ______________

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.

COMPLAINT REGISTERED AGAINST

I wish to file a complaint against the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

Check one:

- ☐ Physician (M.D.)
- ☐ Podiatrist (DPM)
- ☐ Physician Assistant (PA)
- ☐ Midwife
- ☐ Polysomnographer
- ☐ Research Psychoanalyst
- ☐ Unlicensed Provider

Name: ______________________________
(Last Name) (First Name) (Middle Initial)

Office/Facility Name: ____________________ **License Number** (if known)**:** ____________

Address: ______________________________
(Street) (City) (State) (Zip Code)

Phone Number: ______________________________

Has the patient been examined/treated by another professional for this same condition?

☐ **No** ☐ **Yes** **If yes, provide name and address on the Authorization for Release of Medical Information.**

Reason for Treatment:

Date(s) of Treatment:

DETAILS OF COMPLAINT

(Attach additional sheets if necessary)

MEDICAL BOARD
OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

Enforcement Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2528
Fax: (916) 263-2435
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name (Last, First, Middle)	**Date of Birth**
Medical Record Number (If applicable)	**Date of Death (If applicable)**
Control Number	**Social Security Number (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 and/or criminal 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 address below. 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.