Health Care Provider Complaint Form

This infomation MUST be completed to investigate your complaint, as we correspond via U.S. mail. Incomplete forms CANNOT be processed. If you wish to be a **CONFIDENTIAL INFORMANT**, do not fill out the "Complainant Information" section, refer to page 5.

Florida Statutes 456.073, Disciplinary proceeding: (1) The department, for the boards under its jurisdiction, shall cause to be investigated any complaint that is filed before it if the complaint is in writing, signed by the complainant, and legally sufficient. *If an investigation of any subject is undertaken, the Department will furnish to the subject or the subject's attorney a copy of the complaint or document that resulted in the initiation of the investigation.*

Health Care Provider Information:

Name: ____

Last First M.I. Profession License Number

Address: ____

Number & Street City State Zip

Phone number(s): ______________________ Website: ______________________

Complainant Information:

Your Name: ____

Last First M.I.

Address: ____

Number & Street City State Zip

Home Phone: ______________ Work Phone: ______________ Best Time to Call: __________

Patient Information:

Name: ____

Last First M.I.

Address: ____

Number & Street City State Zip

Phone Number: : ______________________________ Date of birth: ______________

Your relationship to the patient:

Parent Son/Daughter Spouse Brother/Sister Friend Legal Guardian Other

Please provide documentation indicating your appointment as the Legal Authority/Guardianship or Personal Representative

The department does not investigate complaints regarding the amount charged for a procedure, broken or missed appointments, customer service, bedside manner, rudeness, professionalism or personality conflicts.

What is the reason for your complaint? Please check all that apply.

Quality of care
Misdiagnosis
Substance Abuse
Advertising

Unlicensed
Abuse
Sexual contact
Insurance Fraud

Misfilled prescription
Impaired provider
Inappropriate prescribing
Excessive test/treatment

Patient abandonment/neglect
Failure to release patient records
Other ______________

Date of Incident: ______________________

If the incident involved criminal conduct contact local law enforcement; have you contacted local law enforcement?
Yes No

If yes, name of contact: ______________________________, date: __________, case number: __________

Agency Name: ____

Providers Who Treated You After the Incident (Use a separate sheet if necessary)

Name: ____
Last First M.I.

Address: ____
Number & Street City State Zip

Name: ____
Last First M.I.

Address: ____
Number & Street City State Zip

Provide a complete description of the complaint/report.
Include facts, details, dates, locations, etc. (Who, what, when and where)

Attach copies of medical records, correspondence, contracts and any other documents that will help support your complaint. Failure to attach records will delay the investigation. (Attach additional sheets if necessary).

Florida Statutes 837.06, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree.

Signature: ____ Date: ______________
(Required to file complaint)

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

To: Any and All Treating Health Care Practitioners or Facilities:
This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants and other persons who have participated in providing any health care or service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, HIV, mental health, drug abuse treatment, psychiatric and psychological records, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes.
This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation.
By signing below, the patient understands, acknowledges and authorizes the Department to release their identity and medical records to law enforcement and other regulatory agencies in appropriate circumstances at the Department's discretion.

A photocopy of this document is as sufficient as the original.

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Print): ___________________________ Signature: ______________________________

D.O.B.: ______________________ SSN: _____________________ Date: ________________

Name of Authorized Person Other than Patient (Print): _______________________________________

Signature of Authorized Person Other than Patient: ____

Witness Name (Print): ________________________ Witness Signature: ________________________

DOH USE ONLY
Reference Number

_________-______________

Unlicensed Practice

Please fill out this form with information regarding individuals engaging in unlicensed activity.

What is your relationship to the subject? ______________________________

How did you become aware of the alleged unlicensed practice? ______________________________

When did you become aware of the alleged unlicensed practice? ______________________________

Location of alleged unlicensed practice: ______________________________

Time and date of treatment or incident: ______________________________

If payment was made, how was subject paid? ______________________________

Does the subject or subject's business accept Medicaid? ______________________________

Does the subject or subject's business accept Medicare? ______________________________

Physical description of subject:

Race: ________ Sex: ____________ Height: __________ Weight: ________ Eye Color: _______

Description of Vehicle:

Year: ________ Make: ____________ Model: ___________ Tag No: ______________ Color: _______

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____

Names and addresses of patients/victims/witnesses aware of your complaint:

Name: ______________________________ Address: ______________________________

Name: ______________________________ Address: ______________________________

Names of other subjects/licensees at the same location or business: ______________________________

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CONFIDENTIAL INFORMANT SECTION

This form is intended for confidential informant information only.

Pursuant to Florida Statutes 456.073(1), the Department may investigate complaints made by a confidential informant if the complaint is legally sufficient, if the alleged violation of law or rule is substantial, and if the department has reason to believe, after prelimary inquiry, that the allegations of the complainant are true.

Your identity will only be disclosed by the department under the order of a judge having jurisdictional authority.

Your Name: ____

Last First M.I.

Address: ____

Number & Street City State Zip

Home Phone: ____________________ Work Phone: ____________________ Best Time to Call:____________

Signature: ____ Date: ______________

Please return completed complaint form to:

Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, FL 32399-3275

Email:
mqa.consumerservices@flhealth.gov

Fax:
(850) 488-0796