



# Health Care Provider Complaint Form

This information MUST be completed to investigate your complaint, as we correspond via U.S. mail. Incomplete forms CANNOT be processed.

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:**

Agency/Company Name (if applicable): \_\_\_\_\_

Your Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Number & Street City State Zip

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

## **Patient Information:**

*Please complete this section if you are filing a complaint on behalf of the patient. If you are the patient, please leave this section blank.*

Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Number & Street City State Zip

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your relationship to the patient:

- Self  Parent  Son/Daughter  Spouse  Brother/Sister  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.**

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: \_\_\_\_\_

**Provide a complete description of the complaint/report.  
Include facts, details, dates, locations, etc. (who, what, when and where)  
Attach additional sheets if necessary.**

**Please make and 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.**

Date of Incident: \_\_\_\_\_

**The complaint form must be signed and returned to the Department.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Required to file complaint)

**You may scan and return the form  
via email to:**

[MQA.consumerservices@flhealth.gov](mailto:MQA.consumerservices@flhealth.gov)

**You may mail the form to:**

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

**You may fax the form to:**

850-488-0796



**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 Activity

**Only complete this page if your complaint is for 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: \_\_\_\_\_

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

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

**Names of other subjects/licenses at the same location or business:** \_\_\_\_\_

\_\_\_\_\_