DIVISION OF MEDICAL QUALITY ASSURANCE  
Enforcement Program

Health care practitioners are regulated by the Department of Health and the action which may be taken is administrative in nature, e.g., reprimand, fine, restriction of practice, remedial education, administrative cost, probation, license suspension or license revocation. The Department cannot represent you in civil matters to recover fees paid or seek remedies for injuries. You may wish to consult a private attorney regarding these matters.

The Department of Health investigates complaints and reports involving health care practitioners and enforces appropriate Florida Statutes.

ISSUES WHICH ARE NOT WITHIN THE AUTHORITY OF THE DEPARTMENT INCLUDE:

- Fee disputes (i.e. broken or missed appointments)
- Billing disputes (i.e., the amount a physician charges for services).
- Personality conflicts
- Bedside manner or rudeness of practitioners (such as the physician or his/her office staff’s attitude or professionalism)

HOW TO FILE A COMPLAINT/REPORT AGAINST A HEALTH CARE PRACTITIONER:

- To file a complaint/report, you must do so in a signed, written report. For your convenience you may use this form providing dates and details about your complaint.
- Use a separate complaint form for each practitioner you wish to file a complaint against.
- Be specific and include copies of pertinent medical records, correspondence, contracts, and any other documents that will help support your complaint.
- Medical records are needed to process your complaint. Since a health care practitioner cannot disclose his or her patient names or records without authorization, the Authorization for Release of Patient Information form included on page 3 must be completed and signed. **Signatures must be witnessed or notarized.**
- The Department will notify you in writing of the status of your complaint throughout the process. Please advise us of any address change.
- If the allegations contained in your complaint/report are determined to be possible violations of applicable laws and rules, your complaint will be opened for investigation.
- Please note that if your complaint is assigned for investigation, a copy of the complaint form will be provided to the health care practitioner pursuant to Florida law.
- The Department may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.
- If you are reporting Medicaid Fraud, you may be entitled to a reward through the Office of the Attorney General. For information and to report Medicaid Fraud, please contact the Attorney General’s Fraud Hotline by calling 1-866-966-7226 or online at [http://ahca.myflorida.com](http://ahca.myflorida.com) and clicking the "Report Fraud" button.
HEALTHCARE PRACTITIONER COMPLAINT FORM

COMPLAINANT/REPORTER

<table>
<thead>
<tr>
<th>Your Name:</th>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Street Address</td>
<td>Apartment/Unit #</td>
<td></td>
</tr>
<tr>
<td></td>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>Home Telephone: ( )</td>
<td>Work Telephone: ( )</td>
<td>Best Time to Call:</td>
<td></td>
</tr>
</tbody>
</table>

SUBJECT OF COMPLAINT/REPORT HEALTHCARE PRACTITIONER INFORMATION

<table>
<thead>
<tr>
<th>Provider's Name:</th>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
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<tbody>
<tr>
<td>Practice Address:</td>
<td>Street Address</td>
<td>Apartment/Unit #</td>
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<td></td>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
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<tr>
<td>Home Telephone: ( )</td>
<td>Work Telephone: ( )</td>
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<tr>
<td>Profession:</td>
<td>(i.e. doctor, dentist, nurse, etc.)</td>
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<tr>
<td>License Number:</td>
<td>(if known)</td>
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PATIENT INFORMATION (Complete this section if Patient is not the same as Complainant/Reporter)

<table>
<thead>
<tr>
<th>Name of Patient:</th>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
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<tbody>
<tr>
<td>Address:</td>
<td>Street Address</td>
<td>Apartment/Unit #</td>
<td></td>
</tr>
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<td></td>
<td>City</td>
<td>State</td>
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<td>Home Telephone: ( )</td>
<td>Work Telephone: ( )</td>
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YOUR RELATIONSHIP TO PATIENT

- Self
- Parent
- Son/Daughter
- Spouse
- Brother/Sister
- Friend
- Other Practitioner
- Legal Guardian/provide court documents
- Other ____________________________

NATURE OF COMPLAINT/REPORT (Please check all that apply.)

- Quality of care
- Misdiagnosis of condition
- Substance abuse
- Advertising violation
- Inappropriate prescribing
- Sexual contact with patient
- Insurance fraud
- Misfilled prescription
- Excessive test or treatment
- Failure to release patient records
- Impairment/medical condition
- Patient abandonment/neglect
- Unlicensed
- Problem other than listed above ____________________________

Have you attempted to contact the practitioner concerning your complaint? Yes Date: __________ No
Would you be willing to testify if this matter goes to a formal hearing? Yes No
If the incident involved criminal conduct, you should contact your local law enforcement authority. Have you contacted your local law enforcement authority? Yes No
If yes, state the name of the person or office that you contacted. ____________________________ When did you make this contact? __________ Please give case number if available.

**NOTE:** If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority/Guardianship or Personal Representative.
PLEASE LIST ANY PRIOR AND/OR SUBSEQUENT TREATING PRACTITIONERS RELATIVE TO YOUR COMPLAINT.

<table>
<thead>
<tr>
<th>Full Name:</th>
<th>Address:</th>
<th>Telephone Number:</th>
<th>Prior Treating</th>
<th>Subsequent Treating</th>
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WITNESSES (PLEASE GIVE FULL NAME, ADDRESS AND TELEPHONE NUMBER)

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<th>Telephone Number:</th>
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Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, and any other documents that will help support your complaint. (attach additional sheets if necessary).

☐ I have attached copies of medical records, correspondence, contracts, and any other documents that will help support your complaint.

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WHAT WOULD SATISFY YOUR COMPLAINT?

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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 official duty shall be guilty of a misdemeanor of the second degree.

Signature: ___________________________ Date: __________________

(Required to file complaint)
PATIENT CONSENT FOR RELEASE OF GENERAL MEDICAL PATIENT RECORDS, INCLUDING: MENTAL HEALTH AND/OR PSYCHOTHERAPY PATIENT RECORDS AND/OR DRUG AND/OR ALCOHOL PATIENT RECORDS

This Patient Consent meets the requirements of the Health Insurance Portability And Accountability Act of 1996 (HIPAA Privacy Law), found at 45 CFR, Part 164.

For the purposes of this release, “patient records,” include, but are not limited to, complete copies of any records, communications and information with respect to general medical, mental health and/or psychotherapy, and/or drug and/or alcohol related, history, diagnosis, progress notes, consultations, examinations, prescriptions, treatments, operative procedures, laboratory and pathological tests and reports, x-rays, admission and discharge reports, and bills.

TO: Any and all treating health care practitioners or facilities

The undersigned has been fully informed and understands, that certain of the patient records, made and kept in connection with the evaluation and/or treatment of __________________________, (the “patient”) at or by_______________, (the facility or practitioner) on or between ________________, may, under Florida and Federal law, be privileged and confidential, and that the patient, individually or by his/her duly authorized representative, pursuant to the HIPAA Privacy Law, and section 395.3025, F.S., with respect to general medical patient records, sections 90.503 and 394.4615, F.S., with respect to mental health and psychotherapy and psychological patient records, and section 397.501, F.S., with respect to drug and/or alcohol related patient records, may refuse to disclose, and prevent the facility or practitioner and any other person from disclosing, such patient records.

Purpose: After being fully informed, and having full understanding of the privileged and confidential status protecting such patient records, the undersigned hereby consents, and authorizes the facility or practitioner, to disclose and release such patient records (or true and correct copies thereof) to the Department of Health and its employees or agents for the purposes of reproduction, investigation or other use for licensure or disciplinary actions, and civil, criminal or administrative proceedings.

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 and at the discretion of the department.

Re-disclosure: The undersigned acknowledges that such patient records may be subject to re-disclosure by the Department, and may no longer be protected by the federal HIPAA Privacy Law.
Waiver: The undersigned expressly waives any and all rights, claims, and causes of action against the facility or practitioner, their employees, agents or servants, solely and specifically for disclosure and release of the patient’s records.

Revocation and Expiration: The undersigned acknowledges that this consent is subject to written revocation at any time to the Department of Health, except to the extent that action has been taken in reliance thereon. In the absence of express revocation, this consent is in effect until related disciplinary proceedings are concluded.

Prohibition on Redisclosure of Drug and Alcohol Treatment Records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Name (Please Print)

Patient Signature          D.O.B.          Social Security Number          Date

Name of Authorized Person other than Patient (Please Print)          Relationship

Signature of Authorized Person Other than Patient

STATE of ________________          COUNTY of ________________

Before me personally appeared ______________________ whose identity is known to me by ______________________(type of identification) and who acknowledges that his/her signature appears above.

Sworn to or affirmed by Affiant before me this ____ day of______, 20___

NOTARY PUBLIC - State of Florida          My Commission Expires

Type or Print Name          Witness Signature (if not notarized)

DOH USE ONLY

Reference Number: __________

INV FORM 381, Revised 01/09, 08/07 12/05, 9/05, Created 01/05