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 and clicking the "Report Fraud" button.

HEALTHCARE PRACTITIONER COMPLAINT FORM

COMPLAINANT/REPORTER

Your Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Telephone: (____)_____ Work Telephone: (____)_____ **Best Time to Call:** _____

SUBJECT OF COMPLAINT/REPORT HEALTHCARE PRACTITIONER INFORMATION

Provider's Name: _____
Last *First* *M.I.*

Practice Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Telephone: (____)_____ Work Telephone: (____)_____

Profession: _____ **(**i.e. doctor, dentist, nurse, etc.)

License Number: _____ (if known)

PATIENT INFORMATION (Complete this section if Patient is not the same as Complainant/Reporter)

Name of Patient: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Telephone: (____)_____ Work Telephone: (____)_____

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 ☐ Inappropriate prescribing ☐ Excessive test or treatment
☐ Misdiagnosis of condition ☐ Sexual contact with patient ☐ Failure to release patient records
☐ Substance abuse ☐ Insurance fraud ☐ Impairment/medical condition
☐ Advertising violation ☐ Misfilled prescription ☐ 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.

Full Name: _____ Address: _____ Telephone Number: _____

☐Prior Treating ☐Subsequent Treating

Full Name: _____ Address: _____ Telephone Number: _____

☐Prior Treating ☐Subsequent Treating

Full Name: _____ Address: _____ Telephone Number: _____

☐Prior Treating ☐Subsequent Treating

WITNESSES (PLEASE GIVE FULL NAME, ADDRESS AND TELEPHONE NUMBER)

Full Name: _____ Address: _____ Telephone Number: _____

Full Name: _____ Address: _____ Telephone Number: _____

Full Name: _____ Address: _____ Telephone Number: _____

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.**

WHAT WOULD SATISFY YOUR COMPLAINT?

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)

the road to quality health care
MQA
begins here

Please mail this form to:
Florida Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275

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:
_____ -- _____