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

Florida Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275

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.

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

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 departments' discretion.

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 (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:
_____--_____

QUESTIONNAIRE TO ACCOMPANY COMPLAINTS OF UNLICENSED PRACTICE

If you know the subject of your complaint, 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 Occurrence of the alleged unlicensed practice: _____

Time/Date/Location of Treatment or Incident: _____

If payment was made, how was subject paid? _____

Does the subject or subject's business accept Medicaid? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No

Physical description of subject:

Race:_____ Sex:_____ Height:_____ Weight:_____ Color of Eyes:_____

Description of Vehicle:

Year:_____ Make:_____ Model:_____ Tag No:_____ Color:_____

Have you notified law enforcement or any other Agency about the offense? ☐ Yes ☐ No

If yes, please provide the case number and name of investigator assigned to your case: _____

Name and telephone number of Agency: _____

_____

Names and addresses of other individuals aware of your complaint:

Name: _____ Address :_____

Name: _____ Address :_____

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

CONFIDENTIAL INFORMANT SECTION:

If you wish to remain anonymous you may become a Confidential Informant. Pursuant to Florida Statutes dealing with the investigation of Criminal Activities, the Department may investigate complaints made by a Confidential Informant. You do not have to provide your name. If you prefer to become a Confidential Informant, your identity will only be disclosed by the department under the order of a judge having jurisdictional authority.

For Official Use Only

_____ ____