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 not the patient.

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.

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:_____ Phone #:_____

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

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/licensees at the same location or business: _____

_____