

This letter is important. If you do not understand it, take it to your local office for help.

هذه رسالة مهمة. إذا كنت لا تفهم نصها فعليك أن تأخذها إلى المكتب المحلي التابع له لمساعدتك فيها.

Arabic

Athöře'athiëëkic. Na cii'ye deetic,ke laarë tennë maktam thiaak ke yin bi yin la kuöny thïn. **Dinka**

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide. **French**

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda. **Spanish**

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение. **Russian**

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. **Serbo-Croatian**

Laù thö naøy raát quan troing. Neáu quyù vò khôâng hieáu noãi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taí ñòa phöøng cuûa quyù vò ñeã ñöôïc giuùp ñôð. **Vietnamese**

Barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi. **Swahili**

FOR OFFICE USE ONLY:
Date signed _____
Received _____
Docket Number _____

**VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
(802) 657-4220 or 800-745-7371**

COMPLAINT FORM

Please Print

Your information

Last name _____ First name _____

Street address _____

City, State, Zip code _____

Business/daytime phone _____ Home phone _____

This is a complaint against a _____ Physician (MD)
_____ Physician Assistant (PA) or Anesthesiologist Assistant (AA)
_____ Podiatrist (DPM)

Full name of Physician, Physician's Assistant, Anesthesiologist Assistant or Podiatrist

Address _____

City, State, Zip code _____

Business phone of Physician, Physician's Assistant or Podiatrist _____

Name and location of health care facility (if known) _____

NATURE OF COMPLAINT: Please describe, in detail, the nature of your complaint against this practitioner. Use the space on the reverse and additional sheets, if necessary.

Please turn over and complete other side

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
PO Box 70
Burlington VT 05402-0070
800-745-7371

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE YOU to furnish to the Vermont Department of Health, Board of Medical Practice, and/or its designated representative, and to the Office of the Attorney General, all medical records and all information, without reservation, within your possession or control pertaining to me, whether oral or written (including records provided to you by other health practitioners or health care institutions), relating to any physical, psychiatric, mental or emotional condition or injury or disease for which you may have been consulted or for which you may have provided services.

Only in regard to this specific authorization for disclosure to the Vermont Department of Health, Board of Medical Practice, and to the Office of the Attorney General, and for no other purpose, I hereby expressly WAIVE confidentiality and/or any privileges or immunities accorded this information by State or Federal law, including materials covered by 42 CFR, Part 2, and I hold you harmless from disclosure of same to the Vermont Department of Health, Board of Medical Practice, pursuant to my request, to evaluate certain aspects of my health care.

THIS AUTHORIZATION is subject to revocation at any time except to the extent that you have already taken action in reliance on it. If not previously revoked, this authorization will terminate upon final action, including a judicial determination, of any action taken by the Board of Medical Practice that is related to this information, or, if no such action is taken, will terminate 365 days from the date hereof.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Department of Health, Board of Medical Practice, or its designated representative, and to the Office of the Attorney General, on a continuing basis until this authorization expires or is revoked.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

Date

Name (printed)

Signature

Address

DATE OF BIRTH _____

Address