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

COMPLAINT FORM

Please Print

Your information
Last name _____ First name _____

Street address _____

City, State, Zip code _____

Business/daytime phone _____ Home phone _____

E-mail _____

This is a complaint against a _____ Physician (MD)

_____ Physician Assistant (PA)

_____ Podiatrist (DPM)

Full name of Physician, Physician Assistant or Podiatrist

_____

Address _____

City, State, Zip code _____

Business phone of Physician, Physician 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 professional. Use the space on the reverse and additional sheets, if necessary.

_____

_____

_____

_____

_____

Please turn over and complete other side

Continue your complaint here_____

Please attach copies of any materials you think will help us review your complaint, such as medical, pharmacy, or insurance records.

We need to be able to review the medical records that relate to this complaint. The patient or the patient's legally authorized representative must sign the release form (attached). We will send you a confirmation letter when we receive your signed Authorization for Release of Medical Records Complaint Form and the signed Authorization for Release of Medical Records.

We will likely be sending a copy of your Complaint Form, the information attached to it, and the Authorization form to the professional who is the subject of this complaint. If this investigation results in formal disciplinary action against the professional, the name and other information about the person filing the complaint may become public. Please call us if you have any questions or concerns.

_____ _____

Your Signature Today's Date

Mail this form to: **VERMONT DEPARTMENT OF HEALTH**
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070

VERMONT

Department of Health
Board of Medical Practice
P.O. 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 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.

NAME (printed) _____ Date of Birth _____

Address _____

Address _____

City/State/Zip _____

Signature _____ Date _____