

The attached complaint form may be submitted by faxing to the Florida Department of Health at (850)-488-0796, or by mailing it to

Division of Medical Quality Assurance
Customer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, FL 32399-3275



**DIVISION OF MEDICAL QUALITY ASSURANCE
Consumer and Investigative Services**

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.

COMPLAINT FORM INSTRUCTIONS

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 with 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 acknowledge receipt of your complaint or report by letter.
- 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 have questions about the complaint process, contact the Consumer Services Call Center in Florida toll free at 1 (888) 419-3456, or the Consumer Services Unit at (850) 245-4339.

Division of Medical Quality Assurance, Consumer Services Unit
4052 Bald Cypress Way, Bin C-75 * Tallahassee, FL 32399-3275
Telephone Number (850) 245-4339 or Toll Free Call Center 1-888-419-3456
Visit us online at www.doh.state.fl.us/mqa



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.)

<input type="checkbox"/> Quality of care	<input type="checkbox"/> Inappropriate prescribing	<input type="checkbox"/> Excessive test or treatment
<input type="checkbox"/> Misdiagnosis of condition	<input type="checkbox"/> Sexual contact with patient	<input type="checkbox"/> Failure to release patient records
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Insurance fraud	<input type="checkbox"/> Impairment/medial condition
<input type="checkbox"/> Advertising violation	<input type="checkbox"/> Misfilled prescription	<input type="checkbox"/> Patient abandonment/neglect
<input type="checkbox"/> Unlicensed	<input type="checkbox"/> 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 complained of 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:
_____	_____	_____
		<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:	Address:	Telephone Number:
_____	_____	_____
		<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:	Address:	Telephone Number:
_____	_____	_____
		<input type="checkbox"/> Prior Treating <input type="checkbox"/> 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)



Please mail this form to:
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 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, 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. This authorization is in effect until related disciplinary proceedings are concluded.

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

Date of Birth

Social Security Number

Date

Name of Authorized Person Other than Patient (Please Print)

Relationship

Signature of Authorized Person Other than Patient

Witness Signature (if not notarized)

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

My Commission Expires

Name (please print)

