NORTH CAROLINA MEDICAL BOARD
PO Box 20007
Raleigh, NC 27619
E-mail: complaints@ncmedboard.org

INSTRUCTION SHEET

- The Board licenses and regulates **physicians and physician assistants (PA)**.
- Complaints filed against **non-licensees** (practices, general medical staff, chiropractors, optometrists, nurses, dentists, podiatrists, etc.) nursing homes or hospitals **will be returned** to you with the appropriate referral address.
- If possible, the complaint should be filed by the **patient** or the patient's legal representative **unless** being submitted by another health care professional.
- The **patient** or the patient's authorized legal representative should **complete** the release of **medical record authorization form** so that necessary records can be obtained to complete the review of your complaint. *See enclosed form.*
- A copy of your complaint **will be provided to the Physician or PA** identified in your complaint for a review and response to the Board.
- Enter the information requested in each section of the complaint form. A separate form is **required** for each Physician or PA complaint. *You may make a copy of this form if additional forms are needed.*
- Remember to **make a copy of the information** you submit to the Board as any materials you provide to the Board will not be returned.
- Please do not use **STAPLES** when you return your complaint form; **paperclips only**.
- Please **review** the enclosed brochure "**A Consumer's Guide**" to understand what happens during the complaint review process.
- Generally once a complaint is submitted to the Board it cannot be **withdrawn**.
- If you have **questions** regarding how to fill out or submit your complaint form you may contact the Complaint Department via email or phone at (919) 326-1109 or 1-800 253-9653, **ext. 501**.

NORTH CAROLINA MEDICAL BOARD
Attn: Complaint Department
PO Box 20007
Raleigh, NC 27619
Complaint Department Telephone Numbers
(919) 326-1109 or 1-800 253-9653, **Ext. 501**

E-mail: complaints@ncmedboard.org

Complaint Form (Online)

NAME OF PERSON MAKING COMPLAINT

Your FULL Name:
(Mr. Mrs. Ms.) _____

Your Mailing Address: _____

_____

Your Daytime Phone# _____

Your EMAIL Address: _____

Patient's **FULL** Name:
(if different than complainant) _____

Patient's **DATE OF BIRTH**: _____

Your relationship to patient: _____

Information about the PHYSICIAN OR PA you are reporting – only 1 name per form

(A complaint submitted in a hospital or practice name will be returned)

Physician or PA FULL Name: _____

Physician or PA Address: _____

_____

Physician or PA Telephone #: _____

STATEMENT OF YOUR COMPLAINT

Typically you will not be contacted by the Board unless clarification or additional information is needed so please provide a **concise account of your major concern** related to the Physician or PA listed on your complaint form. *If you do not have sufficient space then you may attach a separate **typed** document.* Please also answer the **questions** at the bottom of this page.

1. **When** did this event occur? Please list specific dates of service.

2. **Where** did this event occur? Please provide full name of practice or hospital(s).

3. Have you contacted the **Physician or PA** about your concerns? If yes, what was the response?

4. What would you consider to be a **fair resolution** to your complaint? (The Board cannot assist with compensation).

5. How did you **hear** about the NC Medical Board? (circle one or list "other")

Friend/family physician/PA attorney pharmacist other healthcare professional Internet other _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print **FULL** Name of Patient _____ **Patient's** Date of Birth _____

PRINT NAME OF **PHYSICIAN, PA, PRACTICE or HOSPITAL** THAT IS TO RELEASE INFORMATION TO THE BOARD:

_____

NAME OF AGENCY TO WHOM THE INFORMATION IS TO BE RELEASED:

North Carolina Medical Board
Attn: Complaint Department
PO Box 20007
Raleigh, NC 27619

I hereby request and authorize the Physician, PA, Hospital or Practice noted above to release a copy of the patient's medical records for the purpose of reviewing my complaint. This information should include but is not limited to: patient histories, discharge summaries, operative notes, office notes, examination and test results and any reports or information prepared by other persons that may be in your possession.

I understand that this authorization is voluntary. I understand that the agency receiving the information is not a health plan or health care provider and that the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying the *providing* organization, except to the extent that action has already been taken to comply with it. This consent will automatically expire within one year from the date of signature.

_____ _____
Signature of Patient or Legally Responsible Person **Today's Date**

_____
If you are not the patient state your relationship to the patient