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Generally once a complaint is submitted to the Board it cannot be withdrawn.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.
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 __________________________
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