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 and a handful of other medical professionals. For the purposes of this form they are referred to as "**licensees**" of the Board.

- Complaints filed against **non-licensees** (general medical staff, chiropractors, optometrists, nurses, dentists, podiatrists, etc.) 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 licensee** 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** if you are complaining about more than one (1) licensee. 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- Generally once a complaint is submitted to the Board it cannot be **withdrawn**.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, Extension 232, 236 or 261.

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, Extension 232, 236 or 261

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) _____

Your relationship to patient: _____

INFORMATION ABOUT THE LICENSEE YOU ARE REPORTING

Licensee's FULL Name: _____

Licensee's Practice Address: _____

_____

Licensee's Practice 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 **clear concise account of your major concern** related to the licensee listed on your complaint form. If you do not have sufficient space below 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 licensee about your concerns? If yes, what was the licensee's response?

4. What would you consider to be a **fair resolution** to your complaint?

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

PRINT NAME OF LICENSEE or PRACTICE 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 licensee 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 not the patient state your relationship to the patient