MAIL OR FAX FORMS TO:

IOWA BOARD OF MEDICINE
400 SW EIGHTH STREET SUITE C
DES MOINES, IOWA 50309
FAX: 515-281-8641

COMPLAINT FORM

One of the most important ways the Iowa Board of Medicine protects consumers is by investigating their complaints against physicians. This form helps the Board collect basic information to review your complaint. For an explanation of the complaint investigation process, please call the Board's Enforcement Division, 515-281-5847, or visit the Board's website, www.medicalboard.iowa.gov Please provide the following information so that the Board can acknowledge receipt of your complaint and contact you should additional information be needed:

TODAY'S DATE: _____

NAME: _____
(LAST) *(FIRST)* *(MIDDLE INITIAL)*

ADDRESS: _____

DAYTIME PHONE: _____
(AREA CODE)

E-MAIL ADDRESS: _____

PATIENT INFORMATION

NOTE: If you are not the patient, please provide the following information:

NAME: _____
(LAST) *(FIRST)* *(MIDDLE INITIAL)*

ADDRESS: _____

DAYTIME PHONE: _____
(AREA CODE)

E-MAIL ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____
(MONTH/DAY/YEAR)

PATIENT'S GENDER:

☐ **Male**
☐ **Female**
☐ **Non-binary**
☐ **Third gender**
☐ **Transgender**
☐ **Prefer to self-describe**
☐ **Prefer not to say**

PATIENT'S RACE:

☐ **Asian or Pacific Islander**
☐ **Black or African American**
☐ **Hispanic or Latino**
☐ **Native American or Alaska Native**
☐ **White or Caucasian**
☐ **Multiracial or Biracial**
☐ **Other**_____

RELATIONSHIP OF COMPLAINANT TO PATIENT:

☐ **Patient**
☐ **Spouse**
☐ **Relative** *(SPECIFY):*_____
☐ **No Relation**

NAME OF CLINIC/HOSPITAL WHERE CARE OCCURRED

_____

PHYSICIAN INFORMATION

Please provide the following information about the physician(s) who is the subject of your complaint:

1. **PHYSICIAN'S NAME:** _____
   (First & Last)
   OFFICE ADDRESS: _____

   _____

   OFFICE PHONE: _____
   (*AREA CODE)*

2. **PHYSICIAN'S NAME:** _____
   (First & Last)
   OFFICE ADDRESS: _____

   _____

   OFFICE PHONE: _____
   (*AREA CODE)*

3. **PHYSICIAN'S NAME:** _____
   (First & Last)
   OFFICE ADDRESS: _____

   _____

   OFFICE PHONE: _____
   (*AREA CODE)*

COMPLAINT INFORMATION

Please describe complaint, including dates and issues. (Use additional pages if necessary and add copies of records if available.)

QUESTIONS ABOUT COMPLAINT

1. Did you discuss the complaint with the physician? □Yes □No
Explain:

2. Did you obtain an opinion from another physician about your complaint? □Yes □No
Explain:

3. Have you contacted another regulatory agency or an attorney about your complaint? □Yes □No
Explain:

4. Do you have/did you have a professional relationship (business, employment, etc.) with the physician? □Yes □No
Explain:

5. Do you have/did you have a personal relationship with the physician? □Yes □No
Explain:

YOUR EXPECTATIONS

What would you like the Iowa Board of Medicine to do about your complaint?

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(Iowa Board of Medicine)

Patient Name: _____Date of Birth: _____

Phone Number: _____.

Address: _____.

City: _____. State: _____. Zip Code: _____.

I hereby authorize the release of my personally identifiable protected health information to the Iowa Board of Medicine (IBM) for use in a confidential investigation being conducted by the IBM. This authorization includes records of a public, private or confidential nature, including the following:

[x] Consultation	[x] History & Physical	[x] Operative Report
[x] Assessment/Evaluation	[x] Treatment Summary	[x] Social History
[x] Discharge Summary	[x] Lab, X-ray, EKG	[x] Pathology Report

I understand that I may revoke this release in writing at any time, except to the extent that the IBM has already taken action in reliance upon this release. I understand that this release shall remain valid for the duration of the IBM investigation unless revoked by me. I understand that I have a right to inspect the information to be disclosed upon proper notification to and under appropriate conditions as established by the IBM. I understand that my authorization is voluntary and that my health care will not be affected if I do not sign this form. I acknowledge that I have been provided a copy of this authorization.

SPECIFIC RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW I specifically authorize the release of protected health information relating to:
(Please check appropriate boxes)

[X] Mental Health [X] Drug and Alcohol Abuse Records [X] HIV/AIDS Test Results

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Patient or Patient's Authorized Representative **Date**

PROHIBITION ON REDISCLOSURE

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

A photocopy/reproduction of this authorization shall have the same force and effect as the original.