

## COMPLAINT FORM

PLEASE NOTE: THIS IS **NOT** AN APPLICATION FOR MEDICAL MALPRACTICE PRELITIGATION SCREENING.

Do not use this form if you wish prelitigation consideration of a personal injury claim for money damages.

Applications for Prelitigation Screenings are available at [bom.idaho.gov](http://bom.idaho.gov) under the Prelitigation option.

Please mail your printed or typed complaint to:  
**Idaho State Board of Medicine**  
1755 Westgate Dr., Suite 140, Boise, Idaho, 83704.

### COMPLAINANT INFORMATION

PATIENT'S NAME: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

YOUR NAME: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY / STATE / ZIP: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

### RESPONDENT INFORMATION

Please identify the Health Care Provider your complaint is about.

*If this complaint is regarding a profession **not listed below**, please contact the Board to learn where to file your complaint.*

**Medical Doctor (MD)**

**Doctor of Osteopathic Medicine (DO)**

**Physician Assistant (PA)**

**Respiratory Therapist**

**Dietician**

**Athletic Trainer**

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

CITY / STATE / ZIP: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ FAX#: \_\_\_\_\_



## NOTIFICATION

You will be notified of the Idaho State Board of Medicine's (Board) receipt of your complaint. You may be requested to provide additional information and/or documentation supporting your complaint. Any materials (documents, photos, etc.) provided to the Board during the course of the investigation may not be returned.

When the Board conducts an investigation, it is handled in a confidential and discrete manner as required by state law. A request for confidentiality cannot be respected in accordance with fairness and procedural process.

The provider named in your complaint (Respondent) will also be notified and will be provided a copy of your complaint. The Respondent will be requested to answer and provide copies of relevant documents, including medical records. Both you and the Respondent will be updated every 45-60 days until the matter is resolved.

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## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct any hospital, physician or other person who has any information regarding my medical care and treatment to release any and all medical records, reports and/or information to the Idaho State Board of Medicine or to such other representative of the Idaho State Board of Medicine as may be designated, for examination and for copying thereof, upon request for such records, reports or information for the specific purpose of addressing concerns relevant to my medical care and treatment.

I further authorize any hospital, physician or other person who has such information to consult with or discuss such information with any of the above entities or persons.

I further consent that a photocopy of this Authorization may be used in lieu of the original hereof and shall be considered valid for one (1) year from the date of my signature below. This authorization, however, is revocable upon receipt of my written request by the Idaho State Board of Medicine.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signed: \_\_\_\_\_, Patient/Guardian

Printed Name: \_\_\_\_\_, Patient/Guardian

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