



STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH PROFESSIONS
RAE RAMSDELL
DIRECTOR

STEVE HILFINGER
DIRECTOR

Enclosed is the allegation form you requested.

Also enclosed are two (2) "Authorization For Release of Privileged/Client Information" forms for signature by the patient, his/her representative, or guardian, if the patient is a minor. **A sample release form is enclosed to assist you. Additionally, carefully read the following instructions to assist you in accurately filling out the forms:**

- ❖ Include the patient's date of birth and last 4 digits of their social security number, if applicable.
- ❖ Make sure the patient and his/her representative, or guardian signs and dates the form.
- ❖ Mail originals of ALL forms. Do not fax forms.
- ❖ If you are signing this release on behalf of a patient, who is not a minor child, you must provide us with a Letter of Authority, issued by the probate court, which empowers you to act on behalf of the patient.
- ❖ Do not include information for more than one doctor or hospital on the same release form. Doing so will make the form invalid.
- ❖ Do not make any additional markings and/or comments on the release form other than the information required. Doing so will make the form invalid.

Additionally, enclosed is a "Treatment Data" form (you may keep the yellow copy of the form for your records), the "Authorization for Release of Privileged/Client Information" form and the "Treatment Data" form. Upon receipt of the completed documents, your allegation will be reviewed and a determination will be made if licensing action should be considered.

If you have any questions in completing the enclosed forms, or if you need additional forms, please contact our office at the phone number listed below.

Health Investigation Division
Bureau of Health Professions
Telephone: (517) 373-9196

Bureau of Health Professions

Health Investigation Division

P.O. Box 30454

Lansing, MI 48909-9897

(517) 373-9196

ALLEGATION FORM

Authority: Public Act 368 of 1978, as amended

Completion: Voluntary Penalty: None

Office Use Only	
File #:	

I wish to complain against the individual named below. **I understand that this agency and the Licensing Board DO NOT assist citizens seeking reimbursement or resolution of billing and fee disputes.**

INSTRUCTIONS: Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the white copy to the address above. Retain the canary copy for your records. Please complete a separate form for each practitioner you are filing an allegation against. **Please be advised that this agency DOES NOT investigate anonymous allegations.**

Information About You		
Your Name		
Street Address		
City		
State	Zip Code	Country
Patient's Name		
Patient's Date of Birth (MM/DD/YYYY)		
Patient's Last 4 Digits of Their Social Security Number		
Your Telephone Numbers With Area Code		
Cell: ()		
Home: () Work: ()		

Allegation Being Filed Against	
Practitioner's First and Last Name	
Street Address	
City	
State	Zip Code
Practitioner's Telephone Number ()	
Treatment/Incident Date	

Check the profession for which you are lodging an allegation about:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Dietitian or Nutritionist | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Allopathic Physician (MD) | <input type="checkbox"/> Marriage & Family Therapist | <input type="checkbox"/> Osteopathic Physician (DO) | <input type="checkbox"/> Sanitarian |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Nurse (RN or LPN) | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Speech/Language Pathologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Nursing Home Administrator | <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Nurse Aide (CNA) | <input type="checkbox"/> Podiatrist | |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychologist | |

Is there civil actions pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a police report? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we release your name and this information to the practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you testify at an Administrative Hearing if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please provide details of your specific concerns related to the treatment rendered. Attach additional sheets if necessary.

Your Signature	Date
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TREATMENT DATA FORM

NAME OF PATIENT: SMITH MARY P.
LAST FIRST M.I.

Date of Birth: 01/01/1950 Last 4 digits of Social Security Number: 6780

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: JOHN DOE, M.D.

Dates of Treatment:

ADDRESS: 123 MAIN STREET

Beginning: MAY 2010

CITY/STATE/ZIP: LANSING, MI 48910

Ending: SEPTEMBER 2010

TELEPHONE: (517) 361-5858

FULL NAME: GOOD SAMARITAN HOSP.

Dates of Treatment:

ADDRESS: 789 FIRST STREET

Beginning: AUGUST 24, 2010

CITY/STATE/ZIP: LANSING, MI 48912

Ending: AUGUST 31, 2010

TELEPHONE: (517) 361-5676

FULL NAME: _____

Dates of Treatment:

ADDRESS: _____

Beginning: _____

CITY/STATE/ZIP: _____

Ending: _____

TELEPHONE: _____

FULL NAME: _____

Dates of Treatment:

ADDRESS: _____

Beginning: _____

CITY/STATE/ZIP: _____

Ending: _____

TELEPHONE: _____

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Health Professions
Health Investigation Division
P.O. Box 30454
Lansing, MI 48909-9897

Office Use Only

FILE NUMBER:

~ SAMPLE ~

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, MARY SMITH, hereby authorize JOHN DOE, M.D.
(Patient/Client/Representative's Name) (Doctor/hospital/program or other custodian of record name)

1234 Main Street, Lansing MI 48910

(Address of doctor/hospital/program or other custodian of records)

To release/exchange information contained in the records of:

MARY SMITH01/01/19506789

Patient's Name

Date of Birth

Last 4 digits of Social Security Number

1. **Name of person(s) or organizations(s) to whom disclosure is to be made:**

Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Health Professions, Health Investigation Division, 6546 Mercantile Way, Suite 2, Lansing, Michigan 48911 or the Department of Attorney General.

2. **Specific type of information to be disclosed:**

Any and all **MEDICAL** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR, Part 2).

3. **The purpose and need for such disclosure:**

I understand that the Department of Licensing and Regulatory Affairs, Bureau of Health Professions and/or the Department of Attorney General may use any information and records so released in connection with the administration and enforcement of the laws of this State and of the United States.

4. I understand that if I give LARA permission I have the right to change my mind and **revoke** it. This must be in writing to: Privacy Office, Michigan Department of Licensing and Regulatory Affairs, Health Investigation Division, 6546 Mercantile Way, Suite 2, Lansing, MI 48911. I also understand that LARA cannot take back any uses or disclosures already made with my permission. Unless otherwise revoked or if I fail to specify an expiration date, event or condition, this authorization will expire **ONE (1)** year from the signature date.

5. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

A copy of this authorization shall serve in the stead of the original.

Mary Smith

Patient/Client or Representative's Signature

(If signed by a Legal Representative, relationship to the Patient/Client.
A letter of authority may be required)

3/24/2011

Date Signed

Jim Smith

Witness' Signature

3/24/2011

Date Witnessed

3/24/2011

Date Prepared

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Health Professions
Health Investigation Division
P.O. Box 30454
Lansing, MI 48909-9897

Office Use Only
FILE NUMBER:

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, _____, hereby authorize _____
(Patient/Client/Representative's Name) (Doctor/hospital/program or other custodian of record name)

(Address of doctor/hospital/program or other custodian of records)

To release/exchange information contained in the records of:

Patient's Name Date of Birth Last 4 digits of Social Security Number

- Name of person(s) or organizations(s) to whom disclosure is to be made:**
Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Health Professions, Health Investigation Division, 6546 Mercantile Way, Suite 2, Lansing, Michigan 48911 or the Department of Attorney General.
- Specific type of information to be disclosed:**
Any and all **MEDICAL** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR, Part 2).
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A copy of this authorization shall serve in the stead of the original.

Patient/Client or Representative's Signature
(If signed by a Legal Representative, relationship to the Patient/Client.
A letter of authority may be required)

Date Signed

Witness' Signature

Date Witnessed

Date Prepared