



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
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. 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.

Investigations & Inspections Division – Allegations Section
Bureau of Professional Licensing
Telephone: (517) 373-9196

Bureau of Professional Licensing

Investigations & Inspections Division

P.O. Box 30670

Lansing, MI 48909-8170

(517) 373-9196

ALLEGATION FORM

Authority: Public Act 368 of 1978, as amended

Completion: Voluntary Penalty: None

Office Use Only

File #:

Please be advised this agency DOES NOT assist citizens seeking reimbursement or resolution of billing or fee disputes or investigate anonymous allegations. In addition, this agency DOES NOT handle allegations against health care facilities.

INSTRUCTIONS: Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the form to the address above. Please complete a separate form for each practitioner you are filing an allegation against.

Information About You			Allegation Being Filed Against	
Your Name			Practitioner's First and Last Name	
Street Address			Street Address	
City			City	
State	Zip Code	Country	State	Zip Code
Patient's Name			Practitioner's Telephone Number	
Patient's Date of Birth (MM/DD/YYYY)			Treatment/Incident Date	
Patient's Last 4 Digits of Their Social Security Number			Would you like to authorize a person other than yourself to communicate with the Department regarding your allegation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Your Telephone Numbers With Area Code Cell: _____ Home: _____ Work: _____			Name: _____ Address: _____ Telephone Number: _____ Relationship to You: _____	
Check the profession for which you are lodging an allegation about: <div> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Marriage & Family Therapist <input type="checkbox"/> Osteopathic Physician (DO) <input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Allopathic Physician (MD) <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Pharmacist <input type="checkbox"/> Sanitarian <input type="checkbox"/> Athletic Trainer <input type="checkbox"/> Nurse (RN or LPN) <input type="checkbox"/> Pharmacy Technician <input type="checkbox"/> Social Worker <input type="checkbox"/> Audiologist <input type="checkbox"/> Nursing Home Administrator <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Chiropractor <input type="checkbox"/> Nurse Aide (CNA) <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Veterinarian <input type="checkbox"/> Counselor <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Podiatrist <input type="checkbox"/> Dentistry <input type="checkbox"/> Optometrist <input type="checkbox"/> Psychologist </div>				
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	
Please provide details of your specific concerns related to the treatment rendered. Attach additional sheets if necessary.				
Your Signature			Date	

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 Professional Licensing
Investigations & Inspections Division

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FILE NUMBER:

~ SAMPLE ~

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:

CITY/STATE/ZIP: LANSING, MI 48910

Ending:

TELEPHONE: (517) 361-5858

FULL NAME: GOOD SAMARITAN HOSP.

Dates of Treatment:

ADDRESS: 789 FIRST STREET

Beginning:

CITY/STATE/ZIP: LANSING, MI 48912

Ending:

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: _____

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Completion: Voluntary

Penalty: None

Authority: P.A. 368 of 1978, as amended

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Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division

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FILE NUMBER:

TREATMENT DATA FORM

NAME OF PATIENT: _____
LAST
FIRST
M.I.

Date of Birth: _____ **Last 4 digits of Social Security Number:** _____

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

FULL NAME: _____ **Dates of Treatment:**
ADDRESS: _____ **Beginning:** _____
CITY/STATE/ZIP: _____ **Ending:** _____
TELEPHONE: _____

FULL NAME: _____ **Dates of Treatment:**
ADDRESS: _____ **Beginning:** _____
CITY/STATE/ZIP: _____ **Ending:** _____
TELEPHONE: _____

FULL NAME: _____ **Dates of Treatment:**
ADDRESS: _____ **Beginning:** _____
CITY/STATE/ZIP: _____ **Ending:** _____
TELEPHONE: _____

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Completion: Voluntary

Penalty: None

Authority: P.A. 368 of 1978, as amended

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Lansing, MI 48909-8170

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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 SMITH

01/01/1950

6789

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 Professional Licensing, Legal Affairs Division, 611 W. Ottawa, P.O. Box 30670, Lansing, Michigan 48909-8170 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 Professional Licensing 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, Investigations and Inspections Division, 611 W. Ottawa St., Lansing, MI 48933. 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)

1/14/2013

Date Signed

Jim Smith

Witness' Signature

1/14/2013

Date Witnessed

1/14/2013

Date Prepared

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
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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

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

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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