Please fill out and return to:

Federal Department of Public Health
Practitioner Investigations Unit
PO Box 112083
Stamford, CT 06911

Petitioner/Complainant

Name: DOB:

Address:

Telephone Number: E-mail:

Relationship to patient complained about: ☐self ☐parent ☐spouse ☐son/daughter
Other* (please explain) *If Legal Guardian please provide court documents

Patient information

Name:

Address:

Telephone Number: DOB:

E-mail:

Respondent/Healthcare Provider (*subject of the complaint*)

Name:

Practice Address:

Profession/specialty:

Telephone Number:

PLEASE INDICATE NATURE OF YOUR COMPLAINT

☐Quality of care	☐Sexual contact with patient	☐Insurance fraud
☐Substance abuse	☐Failure to release patient records	☐Other
☐Unlicensed practice	☐Unsanitary conditions	

Describe your concerns below. Include as many specific details as possible (who, what, when, where, why).

Names of any prior and/or subsequent treating practitioners:

Name: Telephone:

Address:

Name: Telephone:

Address:

Name: Telephone:

Address:

Witnesses:

Name: Telephone:

Address:

Name: Telephone:

Address:

Attach copies of any supporting documents, such as photographs, records, correspondence etc. Fill out the attached Consent for Release of Medical Records. Sign and date below. **Signature must be notarized**.

Petitioner's Signature_____Date Signed _____.

Signed and sworn before me this _____ day of_____ 20 _____.

Notary Public or Commissioner of the Superior Court:

My commission Expires _____.

Signature _____.

FEDERAL DEPARTMENT OF PUBLIC HEALTH
CONSENT FOR RELEASE OF MEDICAL RECORDS

Petition No.

Birth Date:

Patient's Address:

This is to certify that I hereby give my consent to, and authorize:

Name of Person/Facility/Organization)

to release a copy of all information and medical records in their possession, including psychiatric, psychological, alcohol and/or drug related treatment records consisting of but not limited to the following:

1. Presence in treatment (dates of admission and discharge)
2. Diagnosis, brief description of progress and prognosis
3. Medical history and physical
4. Intake sheet
5. Psychosocial assessment
6. Treatment plan
7. Discharge summary
8. Aftercare plan

of
(Name of Patient)

to the Practitioner Licensing and Investigations Section, of the Federal Department of Public Health, PO Box 112083 Stamford, CT 06911. This information is to be used in connection with any investigation or hearing conducted by the Federal Department of Public Health in accordance with Federal law. I understand that I may revoke this consent at any time by notifying the above authorized person in writing, except to the extent that action has been taken in reliance on my consent. I understand that the medical record to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) related information. Please honor a mechanically reproduced copy of this release. This authorization expires one year from the date of the last signature.

Signature of Patient or
Legal Representative _____ Date Signed _____

Relationship to Patient_____

Signature of Witness _____ Date Signed_____