PAB PHYSICIAN ASSISTANT BOARD

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DEPARTMENT OF CONSUMER AFFAIRS • PHYSICIAN ASSISTANT BOARD

2005 Evergreen Street, Suite 2250, Sacramento, CA 95815

P (916) 561-8780 | F (916) 263-2671 | paboard@dca.ca.gov | www.pab.ca.gov

Instructions for Completing the Consumer Complaint Form

1. Legibly print or type all information.
2. Provide the full name and address of the licensee your complaint is against. Please note that the Physician Assistant Board (Board) only handles complaints against the listed individuals on the second page. Please see the "**A Consumer's Guide to the Complaint Process**" for additional information.
3. Attach a copy of any supporting documents you may have in your possession pertaining to your **specific** complaint; documents may include patient records, photographs, audio or video recordings, correspondence, billing statements, proof of payments, autopsy/toxicology report, police report, court documents, etc.
4. Please sign and date the complaint form.
5. Complete the "**Authorization for Release of Information For The Subject Of The Complaint**" (**Subject** is the physician assistant or other healthcare provider you are complaining about)
6. Complete one of the following medical release forms in their entirety:
   - **"Physician/Provider/Facility Authorization for Release of Information**" (In this form you will list all treating facilities in addition to all relevant treating providers specific to your complaint. If the incident is involving a surgical procedure, it is important that you list any pre-op or post-op providers)

     -OR-
   - "**Kaiser Authorization for Release of Information**" (should care and treatment have been rendered at a Kaiser facility please fill out the enclosed Kaiser form and check if it's a "northern" or "southern" facility)

*** Should the patient be deceased, the person signing the release form(s) must be a legal representative as demonstrated on a durable power of attorney, death certificate, or an executor of will/estate document. **(Please enclose copy of supportive documentation).**

Please Note:

- You must fill out **a separate complaint form for each physician assistant** you wish to file a complaint against.
- The Board **does not have jurisdiction over billing/fee disputes**, general business practices (contracts, office policies, appointment times/duration, etc.) or personal conflicts, unless the behavior in question interferes with the safe delivery of health care. Please contact your insurance company or your physician's or other healthcare provider's office to resolve disputes outside of the Board's jurisdiction. **The Board cannot award any kind of financial compensation.**
- Please be advised that the Board cannot assist with any coordination of patient care. Should you require assistance please contact your insurance company or medical providers.
- Review the brochure, "**A Consumer's Guide to the Complaint Process**", for information about the complaint review process.

For more information visit: **www.pab.ca.gov/Consumers/Complaints/**

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Consumer Complaint Form

COMPLAINT REGISTERED AGAINST

Check one: ☐ **Physician Assistant (PA)** ☐ **Unlicensed Provider**

Subject Information

Last Name	First Name	Middle Initial	Provider's License Number

Office/Facility Name	Phone Number

Street Address

City	State	Zip Code

PERSON REGISTERING COMPLAINT

Last Name	First Name	Middle Initial

Street Address

City	State	Zip Code

Phone Number	Email Address

PATIENT INFORMATION

Patient's Name	Patient's Date of Birth

Your Relationship to Patient

NATURE OF COMPLAINT (Check all that apply)

☐ **Quality of Care** (Misdiagnosis, treatment/medication causing side effects, surgical complications, negligent care, etc.)

☐ **Office Practice** (Misleading advertising, double billing, billing for services not rendered)

☐ **Inappropriate Prescribing**

☐ **Provider Impairment** (Under the influence of drugs or alcohol, mental or physical impairment)

☐ **Sexual Misconduct**

☐ **Unlicensed Activity** (Aiding and abetting unlicensed practice, unlicensed provider)

DETAILS OF COMPLAINT (Attach additional pages if necessary)

State your complaint in chronological order and in detail. In addition, please include dates of treatment and list all relevant treating providers specific to your complaint. It is important that you be specific regarding any allegations of substandard care. Providing a comprehensive narrative of your complaint allows for a more expeditious review process.

Signature	Date

2005 Evergreen St., Suite 2250, Sacramento, CA 95815-3893 ● (916) 561-8780 ● FAX: (916) 263-2671 ● paboard@dca.ca.gov ● www.pab.ca.gov

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Authorization for Release of Information for the Subject of the Complaint

CHECK ALL RECORD TYPES THAT APPLY

- ☐ Medical Records
- ☐ Diagnostic Images
- ☐ HIV/AIDS
- ☐ Alcohol/Drug Abuse
- ☐ Psychiatric

PATIENT INFORMATION

Patient Name

Date of Birth

Date of Death (If applicable)

Medical Record Number (If known)

Control Number

Continued on Page 2

I, the undersigned hereby authorize:

Physician/Provider			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

to disclose medical records in the course of my diagnosis and treatment to the **Physician Assistant Board, Enforcement Program,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have the right to receive a copy of this authorization if requested by me. I understand that I have a right to revoke this authorization by sending written notification to the Physician Assistant Board at the above address. My written revocation will be effective upon receipt by the Physician Assistant Board but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or healthcare provider and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

Patient Signature	Date

- OR -

Legal Representative Name	Relationship to Patient
Legal Representative Signature	Date

NOTE: Failure by a physician or healthcare provider to provide the requested records within 15 days, or a healthcare facility within 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board.

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Physician/Provider/Facility Authorization for Release of Information

CHECK ALL RECORD TYPES THAT APPLY

- ☐ Medical Records
- ☐ Diagnostic Images
- ☐ HIV/AIDS
- ☐ Alcohol/Drug Abuse
- ☐ Psychiatric

PATIENT INFORMATION

Patient Name
Date of Birth
Date of Death (If applicable)
Medical Record Number (If known)
Control Number

I, the undersigned hereby authorize:

Physician/Provider/Facility			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

Physician/Provider/Facility			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

Continued on Page 2

Physician/Provider/Facility			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

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Patient Signature	Date

- OR -

Legal Representative Name	Relationship to Patient
Legal Representative Signature	Date

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Kaiser Authorization for Release of Information

CHECK ALL RECORD TYPES THAT APPLY

- ☐ Medical Records
- ☐ Diagnostic Images
- ☐ HIV/AIDS
- ☐ Alcohol/Drug Abuse
- ☐ Psychiatric

PATIENT INFORMATION

Patient Name

Date of Birth

Date of Death (If applicable)

Medical Record Number (If known)

Control Number

Continued on Page 2

I, the undersigned hereby authorize:

☐ Physician/Provider/Facility: Kaiser Permanente (Northern Facilities)

☐ Physician/Provider/Facility: SCPMG/Kaiser Foundation Hospital (Southern Facilities)

Treatment Date(s)

to disclose medical records in the course of my diagnosis and treatment to the **Physician Assistant Board, Enforcement Program,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have the right to receive a copy of this authorization if requested by me. I understand that I have a right to revoke this authorization by sending written notification to the Physician Assistant Board at the above address. My written revocation will be effective upon receipt by the Physician Assistant Board but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or healthcare provider and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

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