STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

Naturopathic Medicine Committee
1300 National Drive, Suite 150, Sacramento, CA 95834
P (916) 928-4785 F (916) 928-4787 | www.naturopathic.ca.gov

CONSUMER COMPLAINT FORM

Instructions for Filing Your Complaint

- ✓ Fill in the name and address of the naturopathic doctor or unlicensed person claiming to be or practicing as a naturopathic doctor.[1] Include the name, address, and license number (if known) of the person whom you are filing a complaint against as well as the name of the facility or practice group, if applicable. For unlicensed practice, include applicable e-mail or Internet addresses.
- ✓ Fill in your full name, address, and telephone numbers. Also, write this information in the first section of the "Authorization for Release of Patient Health Information" of the reverse side of the Complaint Detail Form. Please note, the "Authorization for Release of Patient Health Information" need only be filled out if your complaint is against a naturopathic doctor (ND).
- ✓ Write your complaint and include as many specific details as possible (who, what, where, why). Include the date(s) of treatment and specific examples of the problems with the care and treatment and use extra sheets of paper, if needed. Send us copies of any documents in support of your complaint which may include patient records, photographs, audiotapes, correspondence, billing statements, proof of payments, advertisements, web sites, etc.
- ✓ If the patient has seen **another naturopathic or medical doctor** for the **same problem**, include the name, address, and date(s) of treatment on the release section of the complaint form.
- ✓ Sign and date the complaint form at the bottom of the page and on the "Authorization for Release of Patient Health Information".

Authorization for Release of Patient Health Information

The "Authorization for Release of Patient Health Information" found below is a legal authorization for the Naturopathic Medicine Committee's staff to obtain information about the patient's care from the doctors and/or medical facilities involved in the medical care. **ANY EXTRA COMMENTS, NOTATIONS, ETC., MAKE THE FORM VOID AND WE WILL HAVE TO ASK YOU TO COMPLETE ANOTHER RELEASE FORM.** If you wish to provide us with additional information, please do so using a separate sheet of paper. If there are more than three naturopathic doctors, physicians, or medical facilities, you may copy the blank form in order to have enough spaces. When this form is completed and signed, it allows the Naturopathic Medicine Committee to order records from **ONLY** the doctors or facilities you have listed on the medical record release form.

Print or **type** the patient's name, date of birth, date of death, and medical record number if applicable in the first section. If we need to contact you to clarify your information, it will delay the review process. Fill in the names and addresses of all other health care providers where the patient was seen for the medical problems **in this specific complaint** (doctors and /or clinics or hospitals, etc.) in the second section. **RETURN PAGES 2, 3, AND 4 TO THE ADDRESS LISTED ABOVE.**

[1] Enforcement authority regarding licensure and unprofessional conduct is authorized by California Business and Professions Code Sections 3660 to 3663. Also see California Code of Regulations, Title 16, Sections 4242 to 4260.

I wish to complain about the individual named below. I understand that the Naturopathic Medicine Committee does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

PERSON YOU WANT TO FILE A CLAIM AGAINST:

SUBJECT INFORMATION *(Naturopathic Doctor or Unlicensed Person Claiming to be an ND) Complete All Known Information.*		
Name: *(Last, First, MI)*		
Business or Employer Name:		
Address: *(Number & Street)*		
City:	**State:**	**Zip Code:**
Business Phone:		
E-mail Address:		
Internet Address:		
Additional Information:		

ABOUT YOU:

PERSON REGISTERING COMPLAINT *(May be Anonymous unless investigation requires an* **Authorization for Release of Patient Health Information***)*		
Name: *(Last, First, MI)*		
Address: *(Number & Street)*		
City:	**State:**	**Zip Code:**
Home Phone:	**Business Phone:**	
E-mail Address:		
Relationship to ND or Person Claiming to be ND:		

NOTE: The "**Authorization for Release of Patient Health Information"** form must be signed and dated **by either the patient or the individual legally authorized to make medical decisions for the patient.** If the patient is unable to sign the release, the form may be signed by: 1) the next of kin, if the patient is deceased (provide a copy of the Death Certificate); 2) the parent of a minor child; or 3) the person named by the patient is a signed Power of Attorney granting the person authority to make **medical decisions** for the patient (provide a copy of this document).

DETAILS OF COMPLAINT *(Who, What, Where, Why, How, When.) Attach Copy of Relevant Documents)*

Signature: _____ _____

Patient Date

Or

_____ _____

Legal Representative Date

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AUTHORIZATION FOR RELEASE
CASE NUMBER: _____

☐ Drug/Alcohol Treatment Records (Initial/Date)_____
☐ Medical Records (Initial/Date)_____
☐ Psychiatric/Therapy/Counseling Records (Initial/Date)_____
☐ Physical Therapy Records (Initial/Date)_____
☐ Employment Records (Initial/Date)_____
☐ Other (Specify) _____ (Initial/Date)_____

TO: _____

_____

_____

You are hereby authorized to make available to the State of California, Department of Consumer Affairs, Naturopathic Medicine Committee, as identified by my initials/date above, any and all information you may have concerning any employment, illness, and injury, medical history, consultation, prescription, treatment, or report of any nature whatsoever, including, but not necessarily limited thereto, all hospital and medical reports relating to the treatment of:

Name: _____

Date of Birth: _____

Social Security Number or Medical Record Number(s):_____

For the period of: _____ **through**_____

This authorization shall become effective immediately and shall remain in effect during the course of investigation and any criminal and/or administrative proceeding(s) arising out of the investigation.

_____ _____

PURPOSE: This authorization is given with the understanding that this information and the records received will be used for official purposes only, including investigation and possible criminal and/or administrative proceedings regarding any violations of the laws of the State of California. I further understand that I have a right to receive a copy of this authorization, if I so request.

REVOCATION: This Authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor and others have acted in reliance upon this Authorization prior to the effective date of the written revocation, if any.

DISCLOSURE: I understand that the Requestor may not lawfully use or disclose any information/documentation obtained for any purpose other than that stated above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A COPY OF THIS AUTHORIZATION (INCLUDING A FAXED COPY) SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ _____

Signature of Patient/Person Authorizing Release Date

NOTE TO THE PROVIDER: Failure by a health care provider to provide the requested records within fifteen (15) working days of receipt of this request and authorization may be a violation of Section 123100 of the California Health and Safety Code and may result in a fine and disciplinary action.