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DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

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STATE OF HAWAII
REGULATED INDUSTRIES COMPLAINTS OFFICE
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
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235 SOUTH BERETANIA STREET, NINTH FLOOR
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HILO OFFICE
345 KEKUANAOA STREET, SUITE 12
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1063 LOWER MAIN STREET, SUITE C-216
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KAUAI OFFICE
3060 EIWA STREET, ROOM 204
LIHUE, HAWAII 96766

INSTRUCTIONS FOR COMPLETING YOUR HEALTH CARE PROVIDER COMPLAINT FORM

1. Legibly print or type all information.

2. Please complete all sections of the attached Health Care Provider Complaint Form. If a particular section does not apply to your situation, simply write "N/A" (not applicable) in the space.

3. Provide the full name (please verify spelling) of the health care provider that you wish to file a complaint against, along with the treatment date(s).

4. Provide a detailed narrative statement outlining your complaint in chronological order. Please include dates, facts, locations, etc. (You may attach additional sheets of paper if necessary.)

5. Complete and sign the attached **AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION AND RECORDS** form and submit it with your complaint form. This document is a legal authorization for the Regulated Industries Complaints Office (RICO) staff to obtain information about the patient's health care from the health care provider(s) involved. **You must complete each section where there is an arrow ► symbol.** Any extra comments, notations, etc., will make the form void, and we will have to ask you to fill out another authorization form.

   The authorization form must be signed and dated by **either the patient or the individual legally authorized to make health care decisions for the patient.** If the patient is unable to sign the authorization form, the form may be signed by: 1) the next of kin, if the patient is deceased (please provide a copy of the death certificate), 2) the parent of a minor child, or 3) the person named by the patient in a signed Power of Attorney granting the person authority to make health care decisions for the patient (please provide a copy of this document). **Failing to complete and submit this form may result in unnecessary delays in the processing of your complaint.**

6. If you have any questions about this form or the procedure that will take place, please contact the department staff at (808) 586-2653. To call Oahu-RICO, dial the following toll free numbers: Kauai 274-3141, extension 62653; Maui 984-2400, extension 62653; Big Island 974-4000, extension 62653; Molokai and Lanai 1-800-468-4644, extension 62653.

Please note RICO has jurisdiction over the following health care professions:

Acupuncture Practitioner	Marriage & Family Therapist	Pharmacy
Audiologist	Naturopathic Physician	Physical Therapist
Chiropractor	Nursing	Physician & Physician's Assistant
Dentist and Dental Hygienist	Nursing home Administrator	Podiatrist
Dispensing Optician	Occupational Therapist	Psychologist
Emergency Medical Technician	Optometrist	Social Worker
Hearing Aid Dealers and Fitters	Osteopathic Physician and Surgeon	Speech Pathologist

This printed material may be made available for individuals with special needs in Braille, large print or audio tape. Please submit your request to the Complaints and Enforcement Officer by calling (808) 586-2666. Rev. 5/2007

STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
REGULATED INDUSTRIES COMPLAINTS OFFICE
CONSUMER RESOURCE CENTER
OAHU OFFICE
235 SOUTH BERETANIA STREET, 9TH FLOOR
HONOLULU, HI 96813
www.hawaii.gov/dcca/rico

HEALTH CARE PROVIDER COMPLAINT FORM

Case No.

For Official Use Only

The company/individual you complained against will be informed of this complaint in order to facilitate resolution of this matter. Your complaint may also be referred to mediation, if appropriate. This complaint will not be processed unless this form is complete, legible, signed (please submit with your **original** signature), dated, includes copies of all available evidence, and accompanied by your completed **Patient's Consent and Authorization for Disclosure of Health Information**.

PERSON FILING COMPLAINT

Please print legibly or type *(Last)* *(First)* *(Middle)*

☐ Mr.
☐ Ms.
☐ Mrs.

Address:	Telephone number where you may be reached (8:00am-4:30pm)
	Residence number:
	Business number:

NAME OF PATIENT (IF OTHER THAN YOURSELF)

Please print legibly or type *(Last)* *(First)* *(Middle)*

☐ Mr.
☐ Ms.
☐ Mrs.

Social Security number (optional, however, this information will assist us in identifying and obtaining the proper patient records):

Address: Telephone Number:	Relationship to Patient: ☐Self ☐Parent ☐Son/Daughter ☐Spouse ☐Brother/Sister ☐ Legal Guardian/provide court documents ☐ Other _____ **NOTE:** If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority or Guardianship.

NAME OF HEALTH CARE PROVIDER YOUR COMPLAINT IS AGAINST

(Please submit a separate complaint form for each health care provider against whom you wish to complain)

☐ Mr.
☐ Ms.
☐ Mrs.

*This complaint cannot be processed without the **full** name of the health care provider. Please verify spelling.

Address:	Profession (See cover letter for list of professions):
	Telephone number:
	License number:
Office/Facility Name:	Treatment Date(s):

Nature of complaint (check all that apply):

[ ] Quality of care
[ ] Inappropriate prescribing
[ ] Excessive testing or treatment
[ ] Misdiagnosis of condition
[ ] Sexual misconduct
[ ] Failure to supervise staff
[ ] Criminal conviction
[ ] Misfilled/mislabeled prescription
[ ] Unlawful Discrimination
[ ] Fees/billing practices
[ ] Problem other than listed above _____

[ ] Substance abuse
[ ] Rude or discourteous behavior
[ ] Impaired by mental or emotional illness
[ ] Fraud (insurance or otherwise)
[ ] Advertising violation
[ ] Drug diversion
[ ] Patient abandonment/neglect
[ ] Unlicensed practice
[ ] Charting irregularities

Please be advised that the Regulated Industries Complaints Office (RICO) does not have authority over issues relating to **fee** or **billing** disputes (i.e., the amount a health care provider charges for services), **rudeness** or **personality conflicts** (such as the health care provider or office staff's attitude), and other issues listed above which may not be addressed in the licensing laws.

If RICO determines that this complaint is a **fee** or **billing** dispute, I consent to referring this complaint to the Department of Commerce and Consumer Affair's Office of Consumer Protection (OCP) for their review and possible disposition. Please note that OCP complaints and any attachments filed with, or referred to OCP will become **public record**, and a copy of your complaint form may be given to the person or company you complained about.

☐ Yes, I Consent this complaint's referral to OCP

If the box above is **not** checked, this complaint will be closed if RICO finds no probable violation of the licensing laws.

Please give full details of your complaint; include dates, facts, details, locations, etc. (attach separate sheet if necessary).
Please attach copies of medical records/health information, correspondence, contracts, and any other documents that will help support your complaint.

OTHER INFORMATION

1. What documents do you have to support your complaint? **Please attach *COPIES* of all documents. Do not submit originals; they will not be returned to you.**

☐ Medical records ☐ Proof of payment/cancelled checks (front and back)

☐ Contracts ☐ Receipts

☐ Invoices/billing statements ☐ Correspondence

☐ Advertisement and/or business card

☐ Other (please list) _____

2. Would you be willing to testify if this matter goes to a formal hearing? ☐ Yes ☐ No

3. Have you contacted the health care provider to try and resolve your complaint?

☐ Yes (Please tell us what happened. Include names of persons contacted and dates of contact.)

If you have not done so, please attempt to resolve your complaint with the health care provider <u>before</u> you file this complaint.

☐ Yes, I am unable to contact the health care provider.

4. What are you seeking as a resolution to your complaint? Please remember that what you are seeking may not be within the jurisdiction of this office.

I certify that all statements in this complaint are true and correct to the best of my knowledge. I understand that RICO is unable to represent private parties in court.

Sign here:	**Date:**

*Please submit this form with your **original** signature and your completed **Patient's Consent and Authorization for Disclosure of Health Information**.

☐ Check here if you have included additional sheets or other material.

This printed material can be made available for individuals with special needs in braille, large print or audio tape. Please submit your request to the Complaints and Enforcement Officer at 586-2666.

LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
LIEUTENANT GOVERNOR

LAWRENCE M. REIFURTH
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AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION AND RECORDS

IMPORTANT: THIS AUTHORIZATION DEALS WITH THE RELEASE, SHARING, DISCLOSURE, AND RECEIPT OF INFORMATION FROM YOUR MEDICAL AND HEALTH CARE RECORDS. READ IT CAREFULLY.

You must complete each section where there is an arrow ► symbol

I, ► _____ , of ► _____
(Patient or Patient's Personal Representative) (Address)
► _____ ► _____
(Date of Birth) (City, State, Zip code)

hereby authorize any health plan, physician, health care practitioner, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to (Patient Name) ► _____ to release, disclose and furnish copies of the following medical and health care information regarding my care and treatment to Regulated Industries Complaints Office, its agents and/or its attorneys (hereinafter referred to as "RICO")

By checking below, I authorize access and limit the authorization to the records described below **(PLEASE CHECK ONE ONLY):**

☐ Records regarding admission and treatment for the following medical condition or injury:

_____ on or about _____
(Condition or Injury) (Date of Service)

☐ Records from the period from _____ to _____

☐ Records confined to the following specified information:_____

☐ I am unable to recall specific treatment dates. Please disclose health information and records for the dates of any treatment I received.

(OVER)

By **initialing** below, I also authorize release of the following portions of the health care records/information.

_____ Mental Health Treatment Records (NOTE: this authorization does not include psychotherapy notes)

_____ HIV or AIDS related records

_____ Alcohol or drug abuse records (NOTE: Applicable only if substance abuse records are disclosed. The information disclosed includes records protected by federal confidentiality rules 42 CFR, part 2. The rules prohibits recipients of such records from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. The general authorization for the release of medical or other information is NOT sufficient for this purpose) If you initial this item, we will send you an additional authorization form to sign.

Term of Authorization: This Authorization is effective from the date I have signed it until the conclusion of RICO's civil or administrative actions, including but not limited to any appeals and any derivative matters or needs.

Revoking the Authorization: I have been advised that I have the right to revoke this authorization by contacting RICO in writing to request that this authorization be cancelled. If I revoke this authorization, the revocation will not apply to records or information that have been released before I notified the record keeper or RICO in writing of my change of mind, and will not apply to records that RICO has relied upon in taking action against a health care practitioner. I understand that my decision to revoke this authorization may impair RICO's ability to investigate a complaint and to pursue disciplinary action against a health care practitioner, and my complaint may be dismissed.

Redisclosure: I understand that the information used and disclosed in accordance with this authorization may be subject to redisclosure by RICO and may no longer be protected by the federal privacy rule. For example, RICO may disclose my records/information to the health care practitioner that is the subject of a law enforcement or oversight matter relating to my health information or his or her attorney; or to a consultant working for RICO or the health care practitioner. My records/information may also be disclosed to me, RICO's personnel, authorized agents or other representatives; any reviewing board, commission, or program; its personnel, authorized agents or other representatives; reviewing Advisory Committee Members and experts retained by RICO; the State of Hawaii Department of Commerce and Consumer Affairs Office of Administrative Hearings and its administrative personnel; other law enforcement agencies with civil or criminal jurisdiction over matters relating to the protected health information; and any other deliberative and/or reviewing bodies.

Purpose of disclosure: I understand that a number of state licensing boards including the Board of Medical Examiners of the State of Hawaii issues licenses to provide health care in the State of Hawaii. RICO, on behalf of the various boards, investigates complaints or reports regarding health care practitioners including physicians and physician assistants in order to determine whether disciplinary or other legal action is needed in order to protect patients and the public interest. I understand that my records and information may be used to perform investigation, prosecution and oversight of health care practitioners as may be required under applicable state and federal laws, including but not limited to the state's professional and vocational licensing laws. A photocopy of this authorization shall be considered as effective and valid as the original.

▶ _____ ▶ _____

(Signature of Patient or Patient's Personal Representative) (Date)

▶ _____

(Print Name of Patient or Patient's Personal Representative)

If applicable, please describe how you are authorized to act as the Personal Representative of the Patient **(and attach verification of authority)**.

_____