State of Maine
Board of Licensure in Medicine
137 State House Station
Augusta, Maine 04333
Telephone: (207) 287-3601
Complaints (within Maine): 1-888-365-9964

Complaint against the Maine License of a Medical Doctor (M.D.) or a Physician Assistant (P.A.)

Your Name:_____ Your Date of Birth:_____
Your Address:_____ Your Phone:_____
Your City:_____ State:_____ Zip Code:_____

Patient Name: _____ Patient Date of Birth:_____
Patient Address:_____Phone:_____
Patient City:_____State:_____Zip Code:_____

COMPLAINT AGAINST LICENSEE: **(CHECK ONE)**
☐ Physician
☐ Physician Assistant

Licensee Name:_____
Licensee Address:_____ Phone: _____
Licensee City:_____State:_____Zip Code: _____

DIRECTIONS: State the facts of your complaint as clearly as possible on the next page of this form. Attach additional sheets if necessary. Include the dates of treatment and names of physicians or physician assistants and other health care providers involved. If you wish to file a complaint against more than one physician or physician assistant, please complete a separate form for each complaint. In addition, please complete the attached authorization for the physicians or physician assistants complained against. Use additional authorizations if there are other sources which have information relating to your complaint. For example, if your complaint happened while you were in a hospital, fill out an authorization for the hospital. Upon receipt of your complaint, a copy will be sent to the physician or physician assistant. The physician or physician assistant has 30 days to respond to your complaint. A copy of the response will be sent to you unless that response would jeopardize patient health or well-being. The Board will review your complaint within approximately 90 days from the date of receipt. Based upon the evidence, the Board may dismiss the complaint, direct further investigation of the complaint, or take disciplinary action. You will be notified of the decision.

(CONTINUE ON NEXT PAGE)

The information in this complaint is true, correct and complete to the best of my knowledge.

Signature: _____
Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

MAINE BOARD OF LICENSURE IN MEDICINE
137 State House Station
Augusta, Maine 04333
Tel: (207) 287-3601

I,_____ of _____
[Individual or authorized representative] [Address]

_____
[City, State, Zip]

hereby authorize _____
[Provider's name]

to release, disclose, and furnish **all individually identifiable medical and health care information**, regarding the following patient, including but not limited to any and all medical/treatment records created by other providers in your possession or the possession of your medical practice, to the **Maine Board of Licensure in Medicine, its agents and/or its attorney (hereafter Board):**

Patient Name: _____ Patient DOB: _____

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

____ Mental health treatment records (*Not including psychotherapy notes)*

____ HIV or AIDS related records

____ Alcohol or drug abuse records

____ Other _____
[Specify]

IMPORTANT: If I have authorized the disclosure of **mental health treatment records/information**,
I **[ ]** do **[ ]** do not want to review these records/information before it is released.
I understand that the review may be supervised or may need to be done by my representative.

NOTICE (applicable only if **substance abuse** records are disclosed**).** The information disclosed includes records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit 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. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Term of Authorization: Except as provided hereinafter, this authorization shall be effective from the date I have signed it until _____. [Cannot exceed 30 months]

Refusal to Sign Release: I understand that I have a right to refuse authorization to disclose all or some health care information. I understand that, if I refuse authorization to disclose all or some health care information to the Board, it may impair the Board's ability to investigate the complaint and to pursue

disciplinary action against a license, and that the complaint may be dismissed. I also understand that no treatment will be conditioned upon my signing this authorization, and that my refusal to sign this authorization cannot constitute grounds to deny treatment.

Revoking the Authorization: I have been advised I have the right to revoke this authorization by contacting _____ in
[Insert Provider's Name]
writing to request this authorization be cancelled.

If I revoke this authorization, the revocation will not apply to records/information that have been released to the Board before I notified the hospital/record keeper in writing of my change of mind. I understand that my decision to revoke this authorization may impair the Board's ability to investigate the complaint and to pursue disciplinary action against a licensee, and that the complaint may be dismissed.

Purpose of Authorization: I understand the Board of Licensure in Medicine issues licenses to practice medicine in the State of Maine. I understand that the Board investigates complaints or reports regarding licensed physicians and physician assistants in order to determine whether disciplinary action is needed in order to protect patients and the public interest. I understand that the information I am providing through this authorization will be used solely in connection with the pending investigation of a complaint or report against a licensee and any subsequent disciplinary proceedings.

Redisclosure: I understand that the information used and disclosed in accordance with this authorization may be subject to redisclosure by the Board of Licensure in Medicine as described above and may no longer be protected by the federal privacy rule. For example, the Board may disclose these records/information to the licensee, his or her attorney or a consultant hired by the Board or the licensee. However, I also understand that all individually identifiable health records/information provided to the Board of Licensure in Medicine pursuant to this authorization shall be considered confidential under Maine state law and shall not be used by the Board for any purpose other than that described above without my express written authorization, unless allowed by law.

Copy of Authorization: I acknowledge that I have retained a signed copy of this authorization. I agree that this authorization is as valid whether in the original, a photocopy, a facsimile, or in electronic form.

DATE: _____ _____
SIGNATURE of Individual, or authorized representative*

_____
PRINTED NAME

_____
Relationship to individual*

***If you are signing on behalf of the individual, please state your relationship to the individual on the line above and attach a copy of the order or document that authorizes you to sign and authorize release of the patient's records.**

Updated 08/09