Filing Reports against Health Care Professionals
IMPORTANT – PLEASE READ
Board Authority

The **Tennessee Department of Health** has the authority for various licensing Health Related Boards whose responsibilities are to protect the public interest. This is accomplished through the enforcement of the particular Statutes of each Health Related Board, which examines, licenses, and oversees the practice of the individual licensees. Reports are received from various sources (i.e. the general public, law enforcement, hospitals and other health care facilities, health professionals, and the news media).

Boards cannot assist with civil or criminal matters and do not represent individual patients. The Statutes allow the Licensure Boards to act on behalf of the people of Tennessee at large. When a Board determines that disciplinary action against a practitioner is necessary, the action focuses on prevention of further problems with the practitioner and the protection of future patients.

The Board has the power to control a practitioner's ability to practice in the future. Any person seeking to recover fees or monetary remedies for injuries, or to resolve child custody issues, employment disputes, or disability claims, should consult a private attorney regarding those matters.

Report Processing and Evaluation

The ***Allegations Report*** form located at http://health.state.tn.us/boards/complaints.htm must be completed in its entirety and should be submitted to the **Office of Investigations**. All materials received with the Report becomes the property of the State of TN and cannot be returned.

The Report will be reviewed by an appropriate Board Consultant and an Attorney assigned by the **Tennessee Department of Health** to determine if there has been a violation of the Statutes or Rules governing the profession in question. If not, the file is closed, and you will be notified in writing of their final decision.

If a statutory violation does exist, the matter(s) will be investigated. You will be notified in writing as to the outcome of the investigation. This is a final decision reached by the Board Consultant and an Attorney based on the finding of the investigation and their application of the law to the findings.

While State law does not allow the staff of the Office of Investigations to give details of any investigation, you may contact the Office to inquire about the general status of the complaint. Please be aware that the reports and/or investigations may take several months to process and complete, depending on the complexity of the issues.

TN Department of Health
Office of Investigations
665 Mainstream Drive, Second Floor
Nashville, TN 37243

Telephone Number 615-741-8485 or Toll Free Number 1-800-852-2187

State of Tennessee
Office of Investigations

Tennessee Department of Health
Office of Investigations
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

Phone (615) 741-8485
TN Toll Free 1-800-852-2187

ALLEGATIONS REPORT

COMPLAINANT

NAME (*FIRST, MIDDLE, LAST)*		**HOME PHONE** ( )
BUSINESS NAME (*IF APPLICABLE*)		**WORK PHONE** ( )
STREET ADDRESS		**CELL PHONE** ( )
CITY/COUNTY	**STATE**	**ZIP**

NAME OF PATIENT (if other than yourself)

NAME (*FIRST, MIDDLE, LAST)*		**HOME PHONE** ( )
BUSINESS NAME (*IF APPLICABLE*)		**WORK PHONE** ( )
STREET ADDRESS		**CELL PHONE** ( )
CITY/COUNTY	**STATE**	**ZIP**

RELATIONSHIP TO PATIENT

( ) PATIENT ( ) FAMILY MEMBER Specify: ( ) LEGAL GUARDIAN ( ) FRIEND

( ) EMPLOYER (attach copies of internal investigation and drug screens) ( ) OTHER Specify:

SUBJECT OF REPORT (*PRACTITIONER*)

NAME (*FIRST, MIDDLE, LAST*)		**PROFESSION: (Dr., Dentist, RN, etc.)**
BUSINESS NAME (*IF APPLICABLE*)		**LICENSE NUMBER, IF KNOWN**
STREET ADDRESS		**WORK PHONE** ( )
CITY/COUNTY	**STATE**	**ZIP**

DETAILS OF COMPLAINT

DETAILS OF COMPLAINT	Please write legibly. Use a separate report form for each individual practitioner**.** Provide pertinent information such as: the sequence of events surrounding your concern in chronological order (by date), the names of witnesses, and copies of documents regarding your report (contracts, reports, or photographs). **Note: All materials received in connection with this report become the property of the Department of Health and cannot be returned.**

WITNESSES

NAME	ADDRESS	PHONE NUMBER
		( )
		( )
		( )
		( )

PLEASE RETURN TO:

Office of Investigations
665 Mainstream Drive, 2nd Floor
Nashville, TN 37243

I have read the above and it is true to the best of my knowledge.

SIGNATURE _____ **DATE** _____

State of Tennessee
Office of Investigations for Health Related Boards

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name	Date of Birth	Social Security Number
Patient Address		

TO: Any and all treating physicians and facilities

I, or my authorized legal representative, hereby authorizes any and all licensed health care practitioners who have participated in providing any care or service to me to discuss any communication, whether confidential or privileged, and to provide **full and complete** patient reports and records, including but not limited to patient histories, x-rays, examination and test results, reports, or information prepared by other persons that may be in your possession, and all financial records to **the Tennessee Department of Health, Office of Investigations** (or any official representative of that Office) for investigation, reproduction, or other use. I understand that the information being disclosed may include diagnosis and treatment related to physical/mental illness, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), communicable diseases, and/or alcohol and drug abuse. The communications and/or documents may also include information protected by a legal privilege and, if so, my signature constitutes the knowing and voluntary consent for the disclosure.

I understand that a photocopy or facsimile of this Authorization shall have the same legal effect as the original.

This Authorization will expire at the conclusion of the investigation and/or any disciplinary proceeding which arises from the filing of the allegations. I have the right to revoke this Authorization at any time by writing to the Office of Investigations, ATTN: PRIVACY OFFICER, 665 Mainstream Drive, 2nd Floor, Nashville, TN 37243, except to the extent that information has already been released and/or action taken based on this Authorization.

Information disclosed and/or released under this Authorization may be redisclosed to organizations and/or persons, and I understand that such disclosures may no longer be protected by state or federal law.

I understand that signing this authorization is a voluntary act. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization for this disclosure.

_____ _____
Signature of Patient Date

If patient is a minor and/or otherwise lacks the capacity to sign:
_____ _____ Signature of Parent or Authorized Legal Representative Date
Relationship to Patient:
Type of Legal Document granting authority (e.g. Power of Attorney) : A copy **MUST** be attached.