

Please fill out and return to:

State of Connecticut
Department of Public Health
Practitioner Investigations Unit
410 Capitol Avenue, MS#12HSR
P.O. Box 340308
Hartford, CT 06134-0308

Petitioner/Complainant	
Name:	DOB:
Address:	
Telephone Numbers: Home	Work
Relationship to patient complained about: self parent spouse son/daughter Other* (please explain)	
*If Legal Guardian please provide court documents	

Patient information <i>(complete this section if Patient is not the same as Petitioner)</i>	
Name:	
Address:	
Telephone Numbers:	DOB:

Respondent/Healthcare Provider <i>(subject of the complaint)</i>	
Name:	
Practice Address:	
Profession/specialty <i>(i.e. physician/cardiology, dentist/general)</i>	
Telephone Number:	

PLEASE INDICATE NATURE OF YOUR COMPLAINT

- | | | |
|--|---|--|
| <input type="checkbox"/> Quality of care | <input type="checkbox"/> Unlicensed practice | <input type="checkbox"/> Unsanitary conditions |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Failure to release patient records | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sexual contact with patient | <input type="checkbox"/> Insurance fraud | |

Names of any prior and/or subsequent treating practitioners:

Name: _____ Telephone: _____

Address: _____

Name: _____ Telephone: _____

Address: _____

Name: _____ Telephone: _____

Address: _____

Witnesses:

Full Name: _____ Telephone: _____

Address: _____

Full Name: _____ Telephone: _____

Address: _____

Attach copies of any supporting documents, such as photographs, records, correspondence etc.
Fill out the attached Consent for Release of Medical Records.
Sign and date below. **Signature must be notarized.**

_____ Dated this day of 20
Petitioner's Signature

Signed and sworn before me this day of 20 .

**Notary Public
Commissioner of Superior Court**

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
CONSENT FOR RELEASE OF MEDICAL RECORDS**

Petition No. _____

Birth Date: _____

Patient's Address: _____

This is to certify that I hereby give my consent to, and authorize:

(Name of Provider/Facility/Organization)

to release a copy of all information and medical records in their possession, including psychiatric, psychological, alcohol and/or drug related treatment records consisting of but not limited to the following:

1. Presence in treatment (dates of admission and discharge).
2. Diagnosis, brief description of progress and prognosis.
3. Medical history and physical.
4. Intake sheet.
5. Psychosocial assessment.
6. Treatment plan.
7. Discharge summary.
8. Aftercare plan.

of _____,
(Name of Patient)

to the Practitioner Licensing and Investigations Section, of the State of Connecticut Department of Public Health, 410 Capitol Avenue, MS# 12HSR, P.O. Box 340308, Hartford, CT 06134-0308. This information is to be used in connection with any investigation or hearing conducted by the Department of Public Health in accordance with Connecticut General Statutes §19a-14(a)(10) and (11). I understand that these records may be provided to the practitioner who is subject to this investigation, and his/her legal representation, as part of the Department's investigation of this matter. I understand that I may revoke this consent at any time by notifying the above authorized person in writing, except to the extent that action has been taken in reliance on my consent. I understand that the medical record to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) related information. Please honor a mechanically reproduced copy of this release. This authorization expires one year from the date of the last signature.

Signature of Patient or Legal Representative

Date Signed

Relationship to Patient

Signature of Witness

Date Signed