COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

DIVISION OF PROFESSIONS AND OCCUPATIONS COMPLAINT FORM
For Health Care Related Professions

Board/Program: _____

For a list of the boards and programs, see the final page of this form

COMPLAINT FILED AGAINST:

Name: _____

License # (if known): _____

Specialty and/or Company (if applicable): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Business _____ Cell _____

Email: _____

COMPLAINT FILED BY:

Name and Company (if applicable): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Business _____ Cell _____

Email: _____

Relationship to the client/patient: _____

Client/Patient Name: _____ Client/Patient date of birth: _____

Date(s) of the Incident: _____

Have you read the Advisory Notice to Complainants ("Advisory Notice")? It is recommended, but not required, that you review the information in the Advisory Notice, which provides instructions about complaints, legal authority of the Division's boards and programs, and information about the investigative process. (Check the box below):

□ Yes □ No

Nature of Complaint (check all that apply): Please note that the items listed below may not apply to all boards or programs with which you are filing the complaint.

□ Substandard practice
□ Mental/physical disability
□ Non-compliance with Board order
□ Overutilization
□ Unlicensed practice
□ Abuse of client/patient
□ Criminal conviction
□ Addiction to drugs/alcohol
□ Misdiagnosis of condition/problem
□ Sexual contact with client/patient
□ Poor communication
□ Failure to release records
□ Fraud
□ Diversion (drug)
□ Failure to properly or accurately complete Health Professional Profile Program (HPPP) information
□ Improper prescriptions
□ Client abandonment
□ Documentation issues
□ Inappropriate care of child client/patient
□ Other, please describe in the box below:

*** Fee disputes** do not fall within the jurisdiction of the Division of Professions and Occupations.

On a separate sheet of paper, type or legibly print your complaint. Please address the following:

1. Provide a chronological summary of your complaint, including dates.
2. List names, addresses and telephone numbers of witnesses including other professionals. Report any police investigation including case number and submit the written report (if available).
3. Attach copies of all documents relevant to your complaint such as letters and other correspondence, police reports, contracts, witness statements.
4. Have you filed a complaint with anyone else, retained an attorney, or had the case reviewed by any experts? If so, please provide detailed information for each.

Dental Complaints Only: Pursuant to section 12-35-129.2(1)(b), C.R.S, if you are filing a complaint with the Colorado Dental Board related to the standard of care delivered to a patient and you are not the patient of record nor a state agency, you must notify the patient of this complaint before filing it with the Colorado Dental Board. By submitting this form, you attest that you are either the patient of record, a state department or agency, or you have notified the patient of this complaint prior to filing it with the Colorado Dental Board.

I ATTEST THAT ALL STATEMENTS MADE BY ME RELATED TO THIS COMPLAINT ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Print Name Signature Date

Important Note: A refusal to sign the "Authorization for Release of Medical Records and Medical Information" form does not limit the board or program's authority to obtain documents. However, it may delay the investigation of your complaint. You should be aware that the board or program may use its subpoena authority to obtain records that are deemed necessary to investigate the complaint.

AUTHORIZATION FOR RELEASE

OF MEDICAL RECORDS AND MEDICAL INFORMATION

I _____ (fill in your name) hereby authorize the release of records and information pertaining to _____ (fill in name of patient) provided by any treating health care provider, hospital, pharmacy or other facility. The records and information may be released to Department of Regulatory Agencies "DORA" and the investigators of the Division of Registration and others directly involved in the review process.

Patient's date of birth: _____

COMPLETE THE INFORMATION BELOW IF the patient is someone other than the person signing this release.

I have authority to authorize release of these records and information because of my relationship to the patient, which is (fill in custodial parent, guardian, legal power of attorney) _____ (If relationship is legal power of attorney, please provide copy of legal document showing power of attorney).

I understand that signing this authorization is voluntary. I understand that the release of these records and this information is for the purpose of investigation and proceedings involving issues relating to the complaint I have submitted to DORA and may include my personal records. I further consent to the use of these records in a criminal investigation or proceeding by any law enforcement agency against the Health Care provider who is the subject of my complaint. I also understand that the board or program may use their subpoena power to obtain records it deems necessary to investigate the complaint.

HIPAA applies only to covered entities, which are defined in the regulations to include only a health plan, health care clearing house and health care provider who transmits certain covered transactions electronically. 45 C.F.R. §160.103. In contrast, state health professional licensure agencies, boards, and programs were specifically included in the definition of a health oversight agency under HIPAA in the preamble to the regulations. 65 Fed. Reg. 82492 (Dec. 28, 2000). As health oversight agencies under HIPAA, these boards and programs are not covered entities and therefore not subject to the requirements of HIPAA.

I understand that this release does not include records of identity, diagnosis, prognosis or treatment maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

_____ _____

Date Signature of complainant

Return this completed form and additional documentation to:

Colorado Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202

LIST OF BOARDS AND PROGRAMS
DIVISION OF PROFESSIONS AND OCCUPATIONS

- Accountancy
- Acupuncture
- Addictions Counselors
- Architects, Engineers and Land Surveyors
- Athletic Trainers
- Audiology
- Barber and Cosmetology
- Boxing
- Chiropractic
- Dental
- Electrical
- Funeral Home and Crematory
- Hearing Aid Providers
- Landscape Architects
- Marriage and Family Therapy
- Massage Therapy
- Medical
- Midwives
- Naturopathy
- Nursing
- Nursing Home Administrators
- Occupational Therapy
- Optometric
- Outfitters
- Passenger Tramway
- Pharmacy
- Physical Therapy
- Plumbing
- Podiatry
- Private Investigators
- Professional Counselors
- Psychology
- Respiratory Therapy
- Social Work
- Speech-Language Pathology
- Surgical Assistants and Surgical Technologist
- Registered Psychotherapy
- Veterinary

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