DIVISION OF PROFESSIONAL REGISTRATION

Michael L. Parson
Governor
State of Missouri

Missouri Department of
Commerce & Insurance
Chlora Lindley-Myers, Director

CENTRAL INVESTIGATIONS UNIT
3605 Missouri Boulevard P.O. Box 1335
Jefferson City, MO 65102-1335
573-526-0162
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri

Don Eggen
Chief Investigator
central.investigations@pr.mo.gov
pr.mo.gov

To: Complainant

From: Don Eggen
Chief Investigator

Re: Explanation of Complaint System

Attached to this letter, please find a complaint packet. The packet contains a complaint form, a narrative sheet and an Authorization to Use and Disclose Protected Healthcare Information, (Authorization).

Please be sure to explain your allegations thoroughly and neatly in typed or written form and include any documentation that you have pertaining to the complaint.

In order for the licensee to release any information regarding healthcare services provided to you or dependent, please complete and sign the attached Authorization. If the form(s) are not returned or incomplete your complaint may be delayed.

The licensee will receive a copy of the complaint and Authorization and will be instructed to respond to the complaint you have filed within thirty (30) days.

Upon receiving a response from the licensee, your complaint will be reviewed by the Central Investigations Unit to make sure all the requested paperwork is included in the complaint file. The licensing agency will then review the entire complaint and response.

You will be notified in writing of the results of this review. Please understand details relating to the investigation, such as the licensee's response, or statements made connected to the investigation and review process are confidential.

Please send the uniform complaint form, release of confidential information form(s), and all pertinent documents to the attention of: Don Eggen, Chief Investigator, Division of Professional Registration, Post Office Box 1335, Jefferson City, MO 65102.

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

CENTRAL INVESTIGATIONS UNIT
POST OFFICE BOX 1335
JEFFERSON CITY, MO 65102
TELEPHONE (573) 526-0162
FAX (573) 751-5649
TDD 800-735-2966

PATIENT	
SOCIAL SECURITY NUMBER	DATE OF BIRTH

1. I authorize the use and disclosure of protected health information as described below; and,
2. Authorize and request: _____ (name of health care provider)
3. TO RELEASE THE FOLLOWING INFORMATION: any and all billing records; medical records charts; medical reports; chart notes; clinical notes; x-rays and/or radiographic studies and reports of the same; reports of consultation; patient histories/patient questionnaires; reports and records of laboratory testing and other testing; any and all correspondence (in any format) and any other records and documents contained in my file; or, if applicable, for each admission, whether In-Patient, Out-patient, or Emergency Room, the entire record for each admission, to include admitting history & physical; discharge summary; reports of consultation; reports and records of laboratory testing and other testing; reports of consultation; x-rays and radiographic studies and reports of the same; and other records and documents for each admission;
4. ☐ Covering all past, present, and future periods of health care; OR ☐ Covering the period of health care from _____ to _____
5. The requested information is to be released to the Central Investigations Unit of the Missouri Division of Professsional Registration (CIU), P.O. Box 1335, Jefferson City, MO 65102.
6. The requested information is to be used or disclosed for the purpose of oversight activities authorized by law, including audits; civil, administrative, or criminal investigations, inspections, licensure, or disciplinary proceedings or actions; or other activities necessary for the CIU or entities subject to government regulatory programs for which information is necessary for determining compliance with program standards.
7. This authorization shall be in force and effect and not expire until (a) I exercise my right of revocation, as described below, (b) the occurrence of the following date/event _____, or (c) one year from the date of execution, whichever occurs first. A photocopy of this authorization is as valid as an original.
8. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so by communicating in writing, with specific reference to this authorization, to the health care provider named in paragraph 2, above, and to the CIU. I understand that the revocation will not apply to information that has already been released in response to this authorization.
9. I understand that I may refuse to sign this authorization. I further understand that the health care provider named in paragraph 2 may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.
10. I understand that after information is disclosed pursuant to this authorization, it is possible that the information may be redisclosed by the recipient and would no longer be protected by applicable medical privacy laws.
11. I understand that the information in the requested health record may include information relating to Hepatitis B or C, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). It may also contain information about behavioral or mental health services, psychiatric and/or psychological evaluation testing and/or treatment, and treatment for alcohol and drug abuse.
12. I understand that any information disclosed pertaining to alcohol/drug abuse is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of such information from making any further disclosure unless further disclosure is expressly permitted by my written consent 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 such information to criminally investigate or prosecute any alcohol or drug abuse patient.

SIGNATURE OF PATIENT, PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (OPTIONAL)

Personally appeared before me, the above-named Patient, Parent/Guardian, or Authorized Representative, known to me to be the person described in and who executed the foreqoing instrument, and acknowledged that he or she executed the same as his or her free act and deed. In testimony thereof, I have hereunto set my hand and affixed my official seal, in the state and county aforesaid, the day, month, and year above written.

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

Save Print Reset

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TELEPHONE (573) 526-0162
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STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
UNIFORM COMPLAINT

Section 575.060 — False Declarations. Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a Class B misdemeanor. PLEASE TYPE OR PRINT IN BLACK INK

I WOULD LIKE TO FILE MY COMPLAINT WITH THE FOLLOWING BOARD:

- ☐ BEHAVIOR ANALYST ADVISORY BOARD
- ☐ BOARD FOR OCCUPATIONAL THERAPY*
- ☐ BOARD FOR RESPIRATORY CARE*
- ☐ BOARD OF CHIROPRACTIC EXAMINERS*
- ☐ BOARD OF EMBALMERS AND FUNERAL DIRECTORS
- ☐ BOARD OF EXAMINERS FOR HEARING INSTRUMENT SPECIALISTS*
- ☐ BOARD OF GEOLOGISTS REGISTRATION
- ☐ BOARD OF PODIATRIC MEDICINE*
- ☐ BOARD OF PRIVATE INVESTIGATOR EXAMINERS
- ☐ BOARD OF THERAPEUTIC MASSAGE*
- ☐ COMMITTEE FOR PROFESSIONAL COUNSELORS*
- ☐ COMMITTEE FOR SOCIAL WORKERS*
- ☐ COMMITTEE OF DIETITIANS*
- ☐ COMMITTEE OF INTERPRETERS*
- ☐ COMMITTEE OF MARITAL AND FAMILY THERAPISTS*
- ☐ COMMITTEE OF PSYCHOLOGISTS*
- ☐ INTERIOR DESIGN COUNCIL
- ☐ OFFICE OF ATHLETICS
- ☐ OFFICE OF ENDOWED CARE CEMETERIES
- ☐ OFFICE OF TATTOOING, BODY PIERCING & BRANDING
- ☐ REAL ESTATE APPRAISERS COMMISSION
- ☐ OTHER _____

*** YOU MUST COMPLETE THE ATTACHED RELEASE FORM FOR THE BOARD, COMMISSION OR COMMITTEE MARKED WITH AN ASTERISK (*). WITH THE RELEASE FORM SIGNED THE CENTRAL INVESTIGATIONS UNIT CAN OBTAIN YOUR MEDICAL OR THERAPEUTIC RECORDS.**

INFORMATION ABOUT YOU

YOUR NAME	TELEPHONE (DAYTIME)	CELL	TELEPHONE (EVENING)

ADDRESS (STREET, CITY, STATE, ZIP)	YOUR OCCUPATION

PREFERRED CONTACT	TELEPHONE	CELL	EMAIL

INFORMATION ABOUT LICENSEE OR PERSON PRACTICING WITHOUT A LICENSE

PERSON NAME AND/OR COMPANY	TELEPHONE

ADDRESS (STREET, CITY, STATE, ZIP)	PROFESSION	LICENSE NO. (IF KNOWN)

	YES	NO
HAVE YOU CONTACTED LICENSEE OR UNLICENSED INDIVIDUAL ABOUT YOUR COMPLAINT? IF YES, DATE _____	☐	☐
HAVE YOU HAD A PROFESSIONAL OR SOCIAL RELATIONSHIP WITH THE PERSON YOU ARE FILING THE COMPLAINT AGAINST? IF SO, PLEASE EXPLAIN _____	☐	☐

	YES	NO
HAVE YOU CONTACTED AN ATTORNEY?	☐	☐
HAS A LAWSUIT BEEN FILED?	☐	☐
IT MAY BE NECESSARY FOR YOU TO TESTIFY AT A HEARING. ARE YOU WILLING TO TESTIFY?	☐	☐

ALL PERTINENT DOCUMENTS NEED TO BE ATTACHED

NAME OF YOUR PRIVATE ATTORNEY (IF APPLICABLE)	TELEPHONE

ADDRESS (STREET, CITY, STATE, ZIP)

WITNESS: IF WITNESSES ARE LISTED, PLEASE PROVIDE CONTACT INFORMATION

NAME	ADDRESS AND TELEPHONE NUMBER

DETAILS OF COMPLAINT

GIVE FULL DETAILS OF YOUR COMPLAINT. Be specific. What happened? When? **USE BLACK INK.** Type or print legibly. Use additional sheets if necessary. Please attach all pertinent documents regarding this complaint.

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

NOTICE: All complaints must be signed. Such signature also authorizes the Board/ Committee/Commission to release a copy of the complaint to the licensee who is the subject of the complaint.	SIGNATURE ▶	DATE