Wisconsin Department of Safety and Professional Services

DIVISION OF LEGAL SERVICES AND COMPLIANCE

Mail To: P.O. Box 7190
Madison, WI 53707-7190

FAX #: (608) 266-2264
Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
Madison, WI 53703

Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

COMPLAINT FORM

Complaint filed by: Mr./Ms./Mrs. (First, Middle, Last)	
Address:	
City: State: Zip:	
County:	Phone # with area code: ( )
Email address:	
Patient name (if applicable): Mr./Ms./Mrs. (First, Middle, Last)	Patient date of birth:
Patient contact information (if applicable):	Is patient deceased? ____ No ____ Yes Date of Death: _____

People and/or Entities the complaint is against:	Profession/Trade
Address:	
City: State: Zip:	
County:	Phone # with area code: ( )
Email address	
If your complaint involves a trade has this project been submitted for review/approval? _____ No _____ Yes _____ Transaction ID	
If your complaint involves a building, when was the building constructed?	

1. When did the incident occur (If you do not know the exact date, make as close an estimate as possible)?

_____

_____

2. Where did the incident occur (include town/city/village/county)?

_____

_____

3. Have you tried to resolve this matter? If so, please provide details.

_____

_____

_____

4. If your complaint is, or has been, under consideration by another agency or court please provide that information.

_____

_____

_____

5. Who else has information related to this incident? Provide names, addresses, email addresses and phone numbers for those persons.

_____

_____

6. Describe the incident. Include as much specific information as possible. Attach additional pages if needed. Attach copies of any relevant documents or evidence such as contracts, photographs, medical records, billing statements, personal notes, pill bottles, etc. It is very important that you do not dispose of any information or evidence even after you have filed a complaint.

_____

_____

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_____ _____

SIGNATURE **DATE**

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INSTRUCTIONS FOR COMPLETING AUTHORIZATION FORMS FOR HEALTH CARE COMPLAINTS

Complete and return Authorization Form only if your complaint involves a health care professional.

Authorization Forms give your permission for our agency to obtain copies of treatment records, discuss that treatment with the persons who provided the treatment, and use the records as part of our inquiry and/or investigation of the complaint and, if necessary, during any hearing that may follow.

You may make additional copies of this blank form to cover additional facilities and/or offices where treatment was provided.

The patient, or other person, if this is legally allowed, will need to fill in the blanks on the form before signing the form and returning it to us.

- **Patient's Name:** Insert the name of the patient whose records we will be requesting.
- **Patient's Date of Birth:** This will be necessary to identify the patient.
- **I, _____ hereby authorize _____**

  Insert the name of the individual authorizing the release of records after the word "I" and insert the name of the individual or facility which treated the patient after the words "hereby authorize".

  Examples: " Metropolitan Hospital "
  " Dr. Jane Doe "
  " Southside Dental Clinic "

- **Signature:** Sign the form legibly.
- **Date:** Put the date the form is signed.
- **Authority for signing:** If the patient is a minor, is deceased, or is not competent to sign, the parent, legal guardian, next of kin, or estate representative should sign:

  Examples: " James Smith, parent of Michael Smith, a minor child "
  " Mary Jones, surviving wife of Henry Jones, deceased "
  " Steve Green, personal representative for Sandy Blue "

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If you do not include the completed Authorization Form(s), we may not be able to investigate your complaint.

If you have any questions about completing the Authorization Form, please contact the department staff at (608) 266-2112.

Thank you for taking the time to complete this document.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Completion of this form is voluntary

Patient's Name: _____ Patient's Date of Birth:_____

I, _____ hereby authorize _____

and all staff or employees of that facility or office to provide the Wisconsin Department of Safety and Professional Services (Department) and its attached Boards, or any attorney, investigator, employee, or agent thereof, with copies of all health care records relating to the above named patient in your possession or under your control, regardless of origin, including, but not limited to, the following: admission records, physical examinations and histories, nurses notes, progress notes, diagnostic test records, physician notes and orders, medication orders and records, operative reports, laboratory work, prescription and dispensing records, x-ray films, radiology reports, anesthesia records, physical therapy records, occupational therapy records, fetal monitoring strips, respiratory therapy records, consultation reports, pathology reports, emergency room records, discharge summaries, drug and alcohol treatment records, and mental health/psychiatric treatment records. This is to include records relating to HIV treatment, if such treatment has been given. I further authorize you to allow these persons to examine and copy any records or information relating to the above named patient. A reproduced copy of this Authorization Form shall be as valid as the original.

This disclosure is being made for the purposes of a legal inquiry and any subsequent proceedings by the Department and its attached Boards. Unless revoked earlier, this consent regarding records is effective until two (2) years from the date of signature. I understand that: (a) I may revoke this authorization at any time by sending a written notice of revocation to the Department at the above address; or by sending a written notice of revocation to the above health care provider; (b) information obtained as a result of this consent may be used after the above expiration date or revocation; (c) the information that the Department receives under this request will not be re-disclosed except in the case of a Department or board proceeding, or a valid open records request and then only under the circumstances permitted by law and re-disclosed information is no longer protected by privacy laws; and (d) the completion or non-completion of this consent has no effect on any treatment, payment, enrollment or eligibility for benefits by any health care provider.

I have been informed, pursuant to Wis. Admin. Code § DHS 92.03(3)(d), that I have the right to inspect and receive a copy of any mental health treatment record materials which are disclosed as a result of this authorization, as required under Wis. Admin. Code §§ DHS 92.05 and 92.06.

I further authorize you to discuss with these persons, any matters relating to the treatment of the above named patient.

_____ _____

Signature Date

_____

Authority for Signing (i.e., Parent of Minor; Guardian of Ward or Incompetent; Personal Representative or Spouse of Deceased)