ALABAMA BOARD OF MEDICAL EXAMINERS
INFORMATION FOR COMPLAINANTS

Overview of Responsibilities

The Alabama Board of Medical Examiners has jurisdiction over investigation of complaints which are placed against medical doctors or doctors of osteopathy. It does **not** have jurisdiction over other health professionals such as podiatrists, dentists or registered nurses. Neither does it have jurisdiction over hospitals, nursing homes, surgical centers or other health care facilities.

Should your complaint be against some health care professional or entity other than a physician, your complaint should be directed to the appropriate regulatory agency.

The Board of Medical Examiners is responsible for receiving and investigating complaints placed against medical doctors or doctors of osteopathy and has authority to conduct investigations, enforce regulations and impose sanctions when a violation of law or regulation has occurred.

The Board has **no jurisdiction** over actions concerning fees.

The Handling of Complaints

The Board of Medical Examiners receives complaints placed against medical doctors or doctors of osteopathy and will determine if the complaint falls within its jurisdiction. If the complaint is within the Board's jurisdiction, an investigation will be conducted.

The complainant is notified of the Board's decision on each complaint. You should note, however, that the proper conduct of an investigation can be a time-consuming process, and it may be several months before the investigation is completed and a decision is reached.

If a violation of the law or of regulation has occurred, the Board may give the physician an opportunity to come into compliance with the law or regulation, or the Board may determine that other action is necessary. If there is no violation of law or of regulation, the file on the complaint is closed.

If the investigation should result in a formal hearing, the Board may subpoena persons to testify at that hearing if it is believed that their testimony is essential to the case.

Filing a Complaint

To initiate an investigation, complaints must be submitted on the Board's Memorandum of Complaint form, which must in turn be provided to the physician for response. It is important that you complete the form and include as much fact as is available, including such things as the date(s) of the alleged action, the physician's full name and address, the exact nature of the complaint, the names of other individuals who might be involved and their relationship to the complaint, as well as any other information which will assist in the investigation. It is also

necessary for you to provide the date of birth and social security number of the patient involved in the complaint. If you are not the patient, it will be necessary for you to obtain that information and include it in the space provided on the form. This information will be vital to us in identifying and obtaining the proper patient charts from hospitals and clinics. Included with these forms is an authorization and release which you need to sign and return with the complaint. This will help expedite the release of those records that are pertinent to your complaint. Please note that if you include any documentation other than the complaint form (medical records, letters, etc.), you should send **photocopies**, since all materials received in connection with a complaint become the property of the Board and cannot be returned.

The Board will acknowledge receipt of your complaint, may contact you for additional information, and will notify you of the Board's decision concerning the complaint.

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
848 Washington Avenue (36104)
P.O. Box 946, Montgomery, AL 36101-0946
(334) 242-4116

P E R S O N A L & C O N F I D E N T I A L
MEMORANDUM OF COMPLAINT

COMPLAINANT

Name (First, Middle, Last)			Home Phone #
Home Address: Street	City	State	Zip
Email Address	Cell Phone #		Work Phone #

Patient

Name (First, Middle, Last)			Home Phone #
Home Address: Street	City	State	Zip
Patient's Date of Birth	Patient's Social Security #		
Email Address	Cell Phone #		Work Phone #

Relationship to Patient

( ) Patient ( ) Family Member *Specify*: _____

( ) Friend ( ) Other *Specify:*_____

MD, DO, or PA that this Complaint Concerns

Name (First, Middle, Last)			Profession: (MD, DO, PA, etc.)
Business Name (If Applicable)			License Number, if known
Email Address			Work Phone #
Work Address: Street	City	State	Zip

MD, DO, or PA that this Complaint Concerns

Name (First, Middle, Last)	Profession: (MD, DO, PA, etc.)
Business Name (If Applicable)	License Number, if known
Email Address	Work Phone #

Work Address:	Street	City	State	Zip

MD, DO, or PA that this Complaint Concerns

Name (First, Middle, Last)	Profession: (MD, DO, PA, etc.)
Business Name (If Applicable)	License Number, if known
Email Address	Work Phone #

Work Address:	Street	City	State	Zip

MD, DO, or PA that this Complaint Concerns

Name (First, Middle, Last)	Profession: (MD, DO, PA, etc.)
Business Name (If Applicable)	License Number, if known
Email Address	Work Phone #

Work Address:	Street	City	State	Zip

MD, DO, or PA that this Complaint Concerns

Name (First, Middle, Last)	Profession: (MD, DO, PA, etc.)
Business Name (If Applicable)	License Number, if known
Email Address	Work Phone #

Work Address:	Street	City	State	Zip

Specific complaint information

Dates that the provider in question cared for the patient: _____

Have you/patient contacted the provider about this complaint? ( ) Yes ( ) No
If Yes, what action was taken? _____

_____

_____

Did other provider(s) treat the patient after the alleged incident? ( ) Yes ( ) No
If Yes, please specify names and address of other provider(s): _____

_____

_____

_____

Have you/patient been treated at any hospitals or urgent care facilities related to this complaint? ( ) Yes ( ) No
If Yes, where?
What action was or is being taken? _____

_____

State exactly what the provider(s) has done or has not done which causes you to make this report. Include as much detail as you have and include *photocopies* of any supporting documents.

Do no write below this line
ATTACH ADDITIONAL PAGES IF NECESSARY

ALABAMA BOARD OF MEDICAL EXAMINERS
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____(*Name of patient or representative)*, hereby authorize _____*(Name of provider or facility)* to disclose the following protected health information to the Alabama State Board of Medical Examiners, a health oversight agency of the State of Alabama:

(1) Complete Medical Record of patient, _____including, but not limited to any and all medical reports/charts, including reports of treatment for substance abuse, Psychiatric/Psychological care, laboratory reports, x-rays, progress notes, nursing notes, computer reports/charts, prescriptions, audio tapes, or clinical abstracts which may have been made or prepared pursuant to, or in connection with, any examination(s), test(s), or evaluation(s) of the undersigned.

(2) Other Documents as Specified:_____
_____

This protected health information is being used and/or disclosed for the following purpose(s):

(1) Investigation by the Board of complaints concerning medical treatments or conduct.

(2) Other (specify) _____

I understand that the protected health information released to the Board of Medical Examiners may be subject to re-disclosure in accordance with state law and the regulations of the Board.

This authorization shall be in force and effect until:

(1) Date (specify) _____ or

(2) Until the conclusion of the Board's investigation, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to _____*(Name of provider or facility)*. I understand that a revocation is not effective to the extent that _____ _____*(Name of provider or facility)* has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

A photocopy of this authorization will be valid as an original thereof.

_____ _____
(Signature of Patient or Personal Representative) *(Print name of Patient or Personal Representative)*

_____ _____
(Date Signed) *(DOB of patient)* *(Relationship to Patient)*

**********Official Use Only**********

The Alabama Board of Medical Examiners, P.O. Box 946, Montgomery, AL 36101-0946
Telephone: 1-800-227-2606

CGF

Investigator: _____

Print Form