

PATIENT EXPERIENCE RECORD

PLEASE NOTE: If the treating physician is not a HDNCMS member, our ability to be of service is limited but, in the interest of improving physician/patient relations, we will try to process your complaint. In all cases and even if your physician is a member of HDNCMS, the opinion of the Committee is advisory only. The HDNCMS has no power to require your physician to accept its advice.

This matter will be directed to the Society's appropriate committee for review at its next scheduled meeting. You will be advised when they have rendered an opinion. Completion of a review normally takes several weeks.

PLEASE PRINT:

PHYSICIAN NAME:

YOUR NAME: _____ **ADDRESS:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE #** _____

DATE(S) OF TREATMENT: _____

Briefly state the problem:(Use the back of this page if necessary. Attach copies of bills or other pertinent documents. Do not send originals. Use black ink or typewriter only.)

Pursuant to Civil Code § 43.96 "The Medical Board of California is the only authority in the state that can take disciplinary action against the license of the physician whom your complaint relates. The toll-free number of the Medical Board of California is (800)633-2322, and is located at 1426 Howe Ave., Suite 54 Sacramento, CA 95825-3236."

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ to furnish medical information concerning _____ (Patient) to :

***HUMBOLDT-DEL NORTE COUNTY MEDICAL SOCIETY
PUBLIC SERVICE AND MEDICAL ETHICS COMMITTEE
P.O. BOX 6457
EUREKA, CA 95502***

Any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below: _____

The information may be used only for the following purposes:

this authorization is effective now and will remain in effect until _____ (date).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

- () parent or guardian of minor patient (to the extent minor could not have consented to the care)
- () guardian or conservator of an incompetent patient
- () beneficiary or personal representative of deceased patient
- () spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

***HUMBOLDT-DEL NORTE COUNTY MEDICAL SOCIETY
P.O. BOX 6457
EUREKA, CA 95502
(707) 442-2367***