CONSUMER COMPLAINT FORM

Please type or print legibly in ink and mail completed form to the Department at the address above.

<table>
<thead>
<tr>
<th>DETAILS ABOUT THE CONSUMER FILING THE COMPLAINT</th>
<th>PROVIDE DETAILS ABOUT THE BUSINESS THAT PROVIDED THE TELEPHONE MEDICAL ADVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PERSON FILING COMPLAINT (COMPLAINANT)</td>
<td>NAME OF BUSINESS COMPLAINT FILED AGAINST</td>
</tr>
<tr>
<td>STREET ADDRESS</td>
<td>STREET ADDRESS</td>
</tr>
<tr>
<td>CITY/STATE/ZIP CODE</td>
<td>CITY/STATE/ZIP CODE</td>
</tr>
<tr>
<td>PHONE WHERE YOU CAN BE REACHED 8am-5pm</td>
<td>PHONE NUMBER OF ADVICE PROVIDER</td>
</tr>
<tr>
<td>DO YOU WANT YOUR NAME WITHHELD DURING THE INVESTIGATION?</td>
<td>NAME OF PERSON THAT PROVIDED THE TELEPHONE MEDICAL ADVICE</td>
</tr>
</tbody>
</table>

Yes ☐ No ☐

SPECIFY MEDICAL ADVICE CONCERN          DATE OF SERVICE

BRIEFLY DESCRIBE YOUR COMPLAINT (BE SPECIFIC…. WHO, WHAT, WHEN, WHERE, HOW) USE ADDITIONAL PAPER IF NECESSARY

Page 2 Must Also Be Completed

Please include as much detail as possible, as well as copies of any documents you have, such as patient records and correspondence that can be used as evidence (do not send original documents).
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please type or print legibly in ink. Please note that if you do not execute this release, the Department of Consumer Affairs may not be able to investigate or forward the complaint.

Patient’s Name: _______________________________ Date of birth*: ________________

I, the undersigned, have authority to authorize and hereby authorize

______________________________________________________________________________________

Print name of telephone medical advice service

______________________________________________________________________________________

Address       City   State  Zip Code

______________________________________________________________________________________

Telephone number (including area code) Registration number

Medical provider’s name

to disclose the above named patient’s medical information pertaining to telephone medical advice services provided to the patient to the Department of Consumer Affairs. I understand that the Department may release these records to another government agency.

Medical information obtained pursuant to this authorization will be used for investigation into, and possibly legal proceedings (administrative or otherwise) following, any violations of California laws and/or regulations.

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

This authorization shall expire three (3) years from the date of signature below.

_____________________________________________ _________________________________
Patient’s or legal representative’s signature   Date

If a legal representative is authorizing this release, please complete the following information:

_____________________________________________ _________________________________
Printed name of legal representative Relationship to Patient

*Date of birth is needed to positively establish the identity of the complainant.