BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834
P (916) 928-8390 |F (916) 928-8392 | www.ombc.ca.gov

INSTRUCTIONS FOR FILING A COMPLAINT AGAINST AN OSTEOPATHIC PHYSICIAN

The function of the Osteopathic Medical Board of California (Board) is to protect consumers and promote the highest professional standards in the practice of osteopathic medicine, the Osteopathic Medical Board of California licenses osteopathic physicians and surgeons.

The Board investigates consumer complaints and uses its enforcement power to ensure practitioners abide by the provisions of the state Business and Professions Code/Medical Practice Act.

California Business and Professions Code - Section 2450-2459.7: Article 21. Provisions Applicable to Osteopathic Physicians and Surgeons.

Instructions for Filing Your Complaint

Except for the name of the Osteopathic Physician your complaint is against, all information requested is voluntary, but failure to provide this information may delay or prevent the investigation of your complaint. Please provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, such as the Attorney General's Office. In completing the complaint form, please do all of the following:

1. Legibly print or type all information.

2. Fill in the full name, address, telephone number, and license number (if known) of the person your complaint is against. This information must also be included in the corresponding section of the Authorization for Release of Patient Health Information Form.

3. Write your complaint in a narrative format and include details such as (dates, names, titles, specific concerns about the treatment provided, and the name(s) and contact information of any witnesses).

4. Attach a copy of any supporting documents you may have in your possession pertaining to your specific complaint. Supporting documents may include patient records, photographs, audio or video recordings, correspondence (e.g. letters, emails, texts), billing statements, proof of payments, police reports, court documents, and internal employment administrative investigations, etc.

5. Complete the "Authorization for Release of Patient Health Information for the Subject (Physician) of the Complaint". This form is necessary to obtain information from the physician you are complaining about.

6. If you were treated by another provider or health facility related to your complaint, please complete one of the following medical release forms in their entirety:

"Other Provider/Facility Authorization for Release of Patient Health Information" (In this form, list all other treating providers or facilities relevant to your complaint. You can add up to three (3) per form).

-OR-

"Kaiser Authorization for Release of Patient Health Information" (If the care and treatment related to your complaint was rendered at a Kaiser facility, fill out the Kaiser form and check if it's a "northern" or "southern" facility).

7. Sign and date the complaint form.

Please Note:

- You must fill out a separate complaint form for each Osteopathic Physician, or unlicensed provider you would like to complain about.

- The Board does not have jurisdiction over billing/fee disputes, general business practices (contracts, office policies, appointment times/duration, etc.) or personal conflicts, unless the behavior in question interferes with the safe delivery of patient care. The Board cannot award any kind of financial compensation, provide legal advice, or assist with lawsuits.

- Please be advised that the Board cannot assist with any coordination of patient care. Should you require assistance please contact your insurance company or medical providers.

Authorization for Release of Medical Information

The Authorization for Release of Patient Health Information form authorizes the Board to obtain medical information and patient records regarding the patient's care from the licensee and/or the facilities involved with the care.

Print or type the patient's name, date of birth, date of death, if patient is deceased, and medical record number (if known). Include the name of the physician/provider, facility name and address, and phone number as outlined in your complaint.

The Authorization for Release of Patient Health Information form must be signed and dated by either the patient or the individual legally authorized to make medical decisions for the patient. If the patient is unable to sign, the form may be signed by:

1. the informant as listed on the death certificate (provide copy of death certificate)

2. the parent of a minor child

3. the person named by the patient in a signed Power of Attorney granting the person authority to make medical decisions for the patient (provide a copy of the durable power of attorney or an executor of will/estate document)

Do not add extra comments or notations on the Release of Patient Health Information form as this will VOID the form and you will be asked to complete another.

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COMPLAINT REGISTERED AGAINST

SUBJECT INFORMATION (Physician)

Last Name	First Name	Middle Initial	License Number

Office/Facility Name	Phone Number

Street Address

City	State	Zip Code

Dates of Treatment: Reason for Treatment:

Has the patient been examined/treated by another professional for this same condition? ☐ **Yes** ☐ **NO**
If yes, complete the form "OTHER PROVIDER/FACILITY AURTHORIZATION FOR RELEASE OF HEALTH INFORMATION" attached below.

Have you filed a complaint with any other agency/department? ☐Yes ☐No

If yes, please provide the name of the agency/department and provide a case number if one has been provided to you.

PERSON REGISTERING COMPLAINT

Last Name	First Name	Middle Initial

Street Address

City	State	Zip Code

Phone Number	Email Address

PATIENT INFORMATION

Patient's Name	Patient's Date of Birth

Your Relationship to Patient

NATURE OF COMPLAINT

Check the box that best describes the nature of your complaint:

- ☐ **Substandard Care** (e.g. Negligent Treatment, Delay in Treatment, etc.)
- ☐ **Unlicensed Provider or Aiding/Abetting the unlicensed practice**
- ☐ **Sexual Misconduct/Harassment**
- ☐ **Unprofessional Conduct** (e.g. Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest, or Conviction)
- ☐ **Office Practice** (e.g. Failure to Provide Medical Records to Patient, Patient Abandonment)
- ☐ **Provider Impairment** (e.g. Drug, Alcohol, Mental, Physical)
- ☐ **Other**

Notice: Pursuant to Section 129 of the Business and Professions Code, "…Each board shall, upon receipt of any complaint respecting a licentiate thereof, notify the complainant of the initial administrative action taken on his complaint within ten days of receipt…"

DETAILS OF COMPLAINT (Attach additional pages if necessary)

State your complaint in chronological order and in detail. In addition, please include dates of treatment and list all relevant treating providers specific to your complaint. It is important that you be specific regarding any allegations of substandard care. Providing a comprehensive narrative of your complaint allows for a more expeditious review process.

DETAILS OF COMPLAINT (continuation from page 5)

Signature	**Date**

INFORMATION COLLECTION, ACCESS, AND DISCLOSURE

Collection and Use of Personal Information. The Executive Director of the Osteopathic Medical Board of California maintains the information you provide on this complaint form. The information is requested pursuant to Business and Professions Code Sections 325 and 326.

Providing Personal Information Is Voluntary. All information requested is voluntary; however, failure to provide the requested information may delay or prevent the investigation of your complaint.

Possible Disclosure of Personal Information. Your completed complaint form becomes the property of the Board and will be used by authorized personnel as appropriate. Information concerning your complaint may be transferred to other governmental or law enforcement agencies. This may include sharing any personal information you provide.

The information you provide may also be disclosed in the following circumstances:

- in response to a Public Records Act request, as allowed by the Information Practices Act;
- to another government agency as required by state or federal law;
- in response to a court or administrative order, a subpoena, or a search warrant.

Contact Information. For questions about this notice or access to your records, you may contact the Osteopathic Medical Board of California 1300 National Drive, Suite 150, Sacramento, CA 95834-1991, (916) 928-8390 or email OsteoEnforcement@dca.ca.gov. You have the right to review the records maintained on you by the Board unless the records are exempt by section 1798.40 of the Civil Code.

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SUBJECT (PHYSICIAN) AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

CHECK ALL RECORD TYPES THAT APPLY

- ☐ Medical Records
- ☐ HIV/AIDS
- ☐ Psychiatric
- ☐ Diagnostic Images
- ☐ Alcohol/Drug Abuse

PATIENT INFORMATION

Patient Name

Date of Birth

Medical Record Number (*If known*) or SSN

Date of Death (*If applicable*)

Subject (Physician) Authorization for Release of Patient Health Information

Patient Name:	

I, the undersigned, hereby authorize the following provider to release, disclose, and discuss information pursuant to my authorization below:

Osteopathic Physician:			
Facility Name:			
Facility Address:			
City:		State:	Zip Code:
Phone Number:	Treatment Date(s):		

By my signature below, I hereby authorize the provider listed above to disclose medical records in the course of my diagnosis and treatment to the State of California, Department of Consumer Affairs ("DCA"), Osteopathic Medical Board of California ("OMBC"), a state regulatory agency, and to discuss that diagnosis and treatment in an investigative interview and any subsequent proceedings with DCA's Division of Investigation ("DOI") a state law enforcement agency. DOI is comprised of peace officers who conduct investigations on behalf of licensing and regulatory boards who are each a "health oversight agency." This disclosure of records and authorization to discuss my care, as authorized herein, is required for official use including investigation and possible administrative and/or criminal proceedings regarding any violations of State or Federal law. This authorization shall remain valid for three years from the date of signature. A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the OMBC at the above address. My written revocation will be effective upon receipt by the OMBC but will not be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider, and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

Patient Signature _____ Date _____

- OR -

Legal Representative Name _____ Relationship to Patient _____

Legal Representative Signature _____ Date _____

NOTE: Failure by a health care provider, or health care facility with electronic medical records to provide the requested certified records within 15 days of receipt of this request and authorization (30 days for a health care facility without electronic records), may constitute violations of Sections 2225 and/or 2225.5 of the Medical Practice Act and may result in further action.

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OTHER PROVIDER/FACILITY AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CHECK ALL RECORD TYPES THAT APPLY

- ☐ Medical Records
- ☐ Diagnostic Images
- ☐ HIV/AIDS
- ☐ Alcohol/Drug Abuse
- ☐ Psychiatric

PATIENT INFORMATION

Patient Name
Date of Birth
Medical Record Number (If known) or SSN
Date of Death (If applicable)

I, the undersigned, hereby authorize the following providers/facilities to release, disclose, and discuss information pursuant to my authorization below:

Other Provider/Facility (1)			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

Other Provider/Facility (2)			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

Other Provider/Facility Authorization for Release of Health Information

Patient Name:	

Other Provider/Facility (3):			
Street Address:			
City:		State:	Zip Code:
Phone Number:	Treatment Date(s):		

By my signature below, I hereby authorize the providers/facilities listed above to disclose medical records in the course of my diagnosis and treatment to the State of California, Department of Consumer Affairs ("DCA"), Osteopathic Medical Board of California ("OMBC"), a state regulatory agency, and to discuss that diagnosis and treatment in an investigative interview and any subsequent proceedings with DCA's Division of Investigation ("DOI") a state law enforcement agency. DOI is comprised of peace officers who conduct investigations on behalf of licensing and regulatory boards who are each a "health oversight agency." This disclosure of records and authorization to discuss my care, as authorized herein, is required for official use including investigation and possible administrative and/or criminal proceedings regarding any violations of State or Federal law. This authorization shall remain valid for three years from the date of signature. A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the OMBC at the above address. My written revocation will be effective upon receipt by the OMBC but will not be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider, and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

Patient Signature	Date

- OR -

Legal Representative Name	Relationship to Patient
Legal Representative Signature	Date

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KAISER AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CHECK ALL RECORD TYPES THAT APPLY

- ☐ Medical Records
- ☐ HIV/AIDS
- ☐ Psychiatric
- ☐ Diagnostic Images
- ☐ Alcohol/Drug Abuse

PATIENT INFORMATION

Patient Name

Date of Birth

Medical Record Number (*If known*) of SSN

Date of Death (*If applicable*)

Patient Name:

I, the undersigned, hereby authorize Kaiser to release, disclose, and discuss information pursuant to my authorization below:

☐ Kaiser Permanente (Northern Facilities)

☐ SCPMG/Kaiser Foundation Hospital (Southern Facilities)

Treatment Date(s):

By my signature below, I hereby authorize the providers/facilities listed above to disclose medical records in the course of my diagnosis and treatment to the State of California, Department of Consumer Affairs ("DCA"), Osteopathic Medical Board of California ("OMBC"), a state regulatory agency, and to discuss that diagnosis and treatment in an investigative interview and any subsequent proceedings with DCA's Division of Investigation ("DOI") a state law enforcement agency. DOI is comprised of peace officers who conduct investigations on behalf of licensing and regulatory boards who are each a "health oversight agency." This disclosure of records and authorization to discuss my care, as authorized herein, is required for official use including investigation and possible administrative and/or criminal proceedings regarding any violations of State or Federal law. This authorization shall remain valid for three years from the date of signature. A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the OMBC at the above address. My written revocation will be effective upon receipt by the OMBC but will not be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider, and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

Patient Signature

Date

- OR -

Legal Representative Name

Relationship to Patient

Legal Representative Signature

Date

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