



KANSAS STATE BOARD OF HEALING ARTS

235 S. Topeka Boulevard – Topeka, KS 66603-3068

ATTN: Complaint Coordinator

Phone: (785) 296-7413 – Toll Free 1-888-886-7205

Fax: (785) 368-7103

COMPLAINT FORM

INSTRUCTIONS: (Please Type or Print)

Please furnish all identifying information for the complainant, the patient and all practitioners and facilities involved in the complaint. When providing your address, the address of the patient or the practitioner, list the street address, not a post office box. Please complete all pages of this form. Additional pages may be added if necessary.

PERSON MAKING COMPLAINT: (Please notify this agency if the following information changes.)

NAME: _____
 First Middle Last Other Names Used

ADDRESS: _____
 Street City State Zip Code

HOME PHONE:() _____ WORK PHONE:() _____

May we contact you at your place of employment? YES _____ NO _____ (Agency working hours are 8:00 a.m. to 4:30 p.m.) Best time to contact you would be? _____ a.m./p.m. to _____ a.m./p.m.

PATIENT INFORMATION:

NAME: _____
 First Middle Last Other Names Used

ADDRESS: _____
 Street City State Zip Code

DATE OF BIRTH: _____

SSN: _____

HOME PHONE:() _____ WORK PHONE:() _____

PRACTITIONER(S) AGAINST WHOM ALLEGATION IS MADE: (Please identify practitioner with the appropriate title: (M.D., D.O., D.C., D.P.M., P.A., P.T., P.T.A., O.T., O.T.A., R.T., A.T., N.D., C.L.)

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE:() _____ PHONE:() _____

FACILITIES INVOLVED IN THE INCIDENT: (Hospitals, Nursing Homes, Clinics, Etc.)

FACILITY: _____ **FACILITY:** _____

ADDRESS: _____ ADDRESS: _____

PHONE:() _____ PHONE:() _____

FACILITY: _____ **FACILITY:** _____

ADDRESS: _____ ADDRESS: _____

PHONE:() _____ PHONE:() _____

WITNESS(ES) TO THE INCIDENT: (If known)

NAME: _____ **NAME:** _____

ADDRESS: _____ ADDRESS: _____

PHONE:() _____ PHONE:() _____
Home and Work Home and Work

NAME: _____ **NAME:** _____

ADDRESS: _____ ADDRESS: _____

PHONE:() _____ PHONE:() _____
Home and Work Home and Work

PLEASE LIST A FRIEND OR RELATIVE WHO WILL KNOW YOUR MOST CURRENT ADDRESS AND PHONE NUMBER.

NAME: _____

ADDRESS: _____

PHONE:() _____
Home and Work

NARRATIVE

Please describe in detail all allegations against the practitioner(s). Describe each incident with specific dates and list any witnesses. Attach copies of any documents you have concerning the allegations. Use additional sheets if necessary.

DATE OF INCIDENT: _____ PATIENT'S NAME: _____
YOUR RELATIONSHIP TO PATIENT, IF OTHER THAN YOURSELF: _____

I acknowledge that the Kansas Board of Healing Arts may provide a copy of this form to the person against whom the allegations are made. I agree to testify in any hearings which may arise as a result of these allegations. The statements I have made are true and correct to the best of my knowledge and belief.

DATE: _____ SIGNED: _____

GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization authorized to provide the information:

_____.

2. The Kansas Board of Healing Arts, (“the Board”) its representatives, agents or employees are specifically authorized to receive and use my health information. Please send information to:

Kansas Board of Healing Arts
ATTN: _____
235 S. Topeka Blvd.
Topeka, Kansas 66603-3068

3. I specifically authorize the release of all of my health information in your possession or control including medical records of every kind, billing information, films, monitor strips, and any record requested by the Board.

4. The purpose of this request is to permit the Kansas Board of Healing Arts access to all of my health information necessary in furtherance of health oversight activities.

5. I understand I have the right to revoke this authorization at any time by notifying the Kansas Board of Healing Arts in writing at 235 S. Topeka Blvd., Topeka Kansas 66603-3068. I understand that the revocation is only effective after it is received by the Board. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it to other health oversight agencies and law enforcement entities as permitted by state law.

7. I understand that if I do not sign this authorization, the Kansas Board of Healing Arts may not be able to fully investigate my complaint. I also understand that in furtherance of health oversight activities, the Kansas Board of Healing Arts possesses subpoena power that permits them to command the disclosure of my health information from certain individuals and entities without my permission. This authorization is intended to permit individuals and entities not subject to the Board’s subpoena power to provide copies of my health information to the Board.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that this authorization will expire upon completion of the Kansas Board of Healing Art’s investigation into the matter(s) about which I am complaining, or upon the completion of any legal proceedings that might arise out of my complaint, whichever event is latest.

Signature of Patient

Date

OR:

Signature of Personal Representative

Date

(signature warrants he/she has authority to sign as Personal Representative)

Patient’s Date of Birth