

**Please fill out and return to:**

State of Connecticut Department of Public Health  
Practitioner Investigations Unit  
410 Capitol Avenue, MS#12HSR  
P.O. Box 340308  
Hartford, CT 06134-0308  
or DPH.PLISComplaints@ct.gov  
or Fax (860) 707-1916

<b>Petitioner/Complainant</b>					
Name:		DOB:			
Address:					
Telephone Numbers: Stationary		Mobile	email		
Relationship to patient complained about:		self	parent	spouse	son/daughter
Other* (please explain)					
*If Legal Guardian please provide court documents					

<b>Patient information</b> <i>(complete this section if Patient is not the same as Petitioner)</i>	
Name:	
Address:	
Telephone Numbers:	<b>DOB:</b>

<b>Respondent/Healthcare Provider</b> <i>(subject of the complaint)</i>	
Name:	
Practice Address:	
<b>Profession/specialty</b> <i>(i.e. physician/cardiology, dentist/general)</i>	
Telephone Number:	

**PLEASE INDICATE NATURE OF YOUR COMPLAINT**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Quality of care             | <input type="checkbox"/> Unlicensed practice                | <input type="checkbox"/> Unsanitary conditions |
| <input type="checkbox"/> Substance abuse             | <input type="checkbox"/> Failure to release patient records | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Sexual contact with patient | <input type="checkbox"/> Insurance fraud                    |  |

HAVE YOU COMPLAINED ABOUT THIS TO ANY OTHER ENTITY?                      Yes                      No

If yes, which entity? \_\_\_\_\_

**Describe your concerns below.** Include as many specific details as possible (who, what, when, where, why).

Please attach additional pages as necessary.

**Names of any prior and/or subsequent treating practitioners:**

Name: Telephone:

Address:

---

Name: Telephone:

Address:

---

Name: Telephone:

Address:

---

**Witnesses:**

Full Name: Telephone:

Address: email:

---

Full Name: Telephone:

Address: email:

---

Attach copies of any supporting documents, such as photographs, records, correspondence etc.  
Fill out the attached Consent for Release of Medical Records.  
Sign and date below. **For complaints against physicians, form must be signed in front of a notary.**

\_\_\_\_\_  
**Petitioner's Signature**

**Dated this      day of      20**

**Signed and sworn before me this      day of      20      .**

---

**Notary Public  
Commissioner of Superior Court**

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
CONSENT FOR RELEASE OF MEDICAL RECORDS**

Petition No. \_\_\_\_\_

Birth Date: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

This is to certify that I hereby give my consent to, and authorize:

\_\_\_\_\_  
(Name of Provider/Facility/Organization)

to release a copy of all information and medical records in their possession, including psychiatric, psychological, alcohol and/or drug related treatment records consisting of but not limited to the following:

1. Presence in treatment (dates of admission and discharge).
2. Diagnosis, brief description of progress and prognosis.
3. Medical history and physical.
4. Intake sheet.
5. Psychosocial assessment.
6. Treatment plan.
7. Discharge summary.
8. Aftercare plan.

of \_\_\_\_\_,  
(Name of Patient)

to the Practitioner Licensing and Investigations Section, of the State of Connecticut Department of Public Health, 410 Capitol Avenue, MS# 12HSR, P.O. Box 340308, Hartford, CT 06134-0308. This information is to be used in connection with any investigation or hearing conducted by the Department of Public Health in accordance with Connecticut General Statutes §19a-14(a)(10) and (11). I understand that these records may be provided to the practitioner who is the subject of this investigation, and his/her legal representation, as part of the Department's investigation of this matter. I understand that I may revoke this consent at any time by notifying the above authorized person in writing, except to the extent that action has been taken in reliance on my consent. I understand that the medical record to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) related information. Please honor a mechanically reproduced copy of this release. This authorization expires one year from the date of the last signature.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date Signed