



STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
BOARD OF REGISTERED NURSING
 PO Box 944210, Sacramento, CA 94244-2100
 P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov
 Louise R. Bailey, MEd, RN, Executive Officer



COMPLAINT

Please print or type

SUBJECT INFORMATION <i>(Registered Nurse (RN), Applicant Or Unlicensed Person Claiming To Be An RN – Complete All Known Information.)</i>		
Name (Last, First, Middle):	RN Number:	
Home Address (Number & Street):		
City:	State:	Zip Code:
Employer:		
Business Address (Number & Street):		
City:	State:	Zip Code:
Home Phone:	Business Phone:	
Additional Information (Birthdate, Former Name, etc.):		

PERSON REGISTERING COMPLAINT		
Name (Last, First, Middle):		
Business Name:		
Address (Number & Street):		
City:	State:	Zip Code:
Home Phone:	Business Phone:	
Relationship to Nurse (*Patient, Coworker, Friend, etc.):		
<i>*If you are the patient or a patient's legal representative, please complete the attached Release Form</i>		

DETAILS OF COMPLAINT <i>(Who, What, Where, When, Why, How; Include Copy of Relevant Documents; List Any Witnesses & Telephone Numbers. Use "Tab" to continue on next page if additional room is necessary.)</i>

Your Signature

Date

DETAILS OF COMPLAINT (Continued)



AUTHORIZATION FOR RELEASE

CASE NUMBER: _____

- | | |
|---|---------------------|
| <input type="checkbox"/> Drug/Alcohol Treatment Records | (Initial/Date)_____ |
| <input type="checkbox"/> Medical Records | (Initial/Date)_____ |
| <input type="checkbox"/> Psychiatric/Therapy/Counseling Records | (Initial/Date)_____ |
| <input type="checkbox"/> Pharmacy Records | (Initial/Date)_____ |
| <input type="checkbox"/> Employment Records | (Initial/Date)_____ |
| <input type="checkbox"/> Grievance/Grievance Settlement Records | (Initial/Date)_____ |
| <input type="checkbox"/> Other (Specify) _____ | (Initial/Date)_____ |

TO:

You are hereby authorized to make available to the State of California, Department of Consumer Affairs, Board of Registered Nursing, **as identified by my initials/date above**, any and all information you may have concerning any employment, illness, and injury, medical history, consultation, prescription, treatment, or report of any nature whatsoever, including, but not necessarily limited thereto, all hospital and medical reports relating to the treatment of:

Name: _____

Date of Birth: _____

**Social Security Number or
Medical Record Number(s):** _____

For the period of: _____ **through** _____

This authorization shall become effective immediately and shall remain in effect during the course of investigation and any criminal and/or administrative proceeding(s) arising out of the investigation.

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PURPOSE: This authorization is given with the understanding that this information and the records received will be used for official purposes only, including investigation and possible criminal and/or administrative proceedings regarding any violations of the laws of the State of California. I further understand that I have a right to receive a copy of this authorization, if I so request.

REVOCAION: This Authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor and others have acted in reliance upon this Authorization prior to the effective date of the written revocation, if any.

DISCLOSURE: I understand that the Requestor may not lawfully use or disclose any information/documentation obtained for any purpose other than that stated above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A COPY OF THIS AUTHORIZATION (INCLUDING A FAXED COPY) SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Signature of Patient/Person Authorizing Release

Date

NOTE TO THE PROVIDER: Failure by a health care provider to provide the requested records within fifteen (15) working days of receipt of this request and authorization may be a violation of Section 123100 of the California Health and Safety Code and may result in a fine and disciplinary action.