SAN DIEGO COUNTY MEDICAL SOCIETY

Attention Complaints Department
5575 Ruffin Rd., Suite 250
San Diego, CA 92123

Experience Record

Date Mailed: __________

The San Diego County Medical Society is a non-profit private organization of physicians and surgeons, dedicated to maintaining quality medical care and improving patient relationships. SDCMS has a variety of committees volunteering their time toward these goals.

The San Diego County Medical Society recommends that you frankly discuss the complaint which you have with your physician directly before asking the Society to assist in resolving any dispute. This procedure generally resolves most problems.

Please note- if the doctor is NOT an SDCMS member, we are unable to assist in mediating your complaint.

COMPLAINANT: ____ (Please print name)

PHYSICIAN(S): ____ (Please print name)

ADDRESS: ____
____ (City) (State) (Zip)

ADDRESS: ____
____ (City) (State) (Zip)

PHONE NO.: ____ (Home) (Work)

PHONE NO.: ____ (Office)

Date of treatment: ____ (Month) (Day) (Year)

Date you contacted doctor about this dispute: ________________________________ (Month) (Day) (Year)

Name of patient (if not the complainant):

____
(Name and relationship to complainant)

Address: ____
(Include city, state. zip and phone number)

BRIEFLY STATE PROBLEM ON ADDITIONAL SHEET.

(ATTACH BILLS AND ALL PERTINENT DOCUMENTS)

Authorization For Disclosure to and Use of Protected Health Information by the San Diego County Medical Society

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, your physician may not use or disclose your individually identifiable health information except as provided in the physician practice's Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby authorize the medical practice identified on the accompanying complaint to use and disclose health information concerning

____
(patient name and address) as follows:

Health information to be used or disclosed:
Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

____

All psychotherapy notes may be released, except as specifically provided below:

____

This health information may be disclosed to the San Diego County Medical Society. The information may be used only to investigate and attempt to resolve the accompanying complaint.

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization. I understand that my health cam treatment or benefits will not be affected whether I sign or do not sign this form. This authorization is effective now and will remain in effect until the San Diego County Medical Society has finished handling this grievance. I understand that I have the right to receive a copy of this authorization.

Signed: ________________________________ Dated: ________________________________

Print Name: ________________________________

If not signed by the patient, please indicate relationship:

- ❑ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient