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

Petitioner/Complainant	
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	

Patient information (*complete this section if Patient is not the same as Petitioner*)	
Name:	
Address:	
Telephone Numbers:	**DOB:**

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

PLEASE INDICATE NATURE OF YOUR COMPLAINT

☐ Quality of care	☐ Unlicensed practice	☐ Unsanitary conditions
☐ Substance abuse	☐ Failure to release patient records	☐ Other
☐ Sexual contact with patient	☐ 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 and physician assistants form must be signed in front of a notary**.

_____ **Dated this day of 20**

Petitioner's Signature

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