GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Instructions for Filing a Complaint

Please fill out the following attached forms:

- ❖ NOTE: All nursing complaints file on-line at: www.Michigan.gov/MiPLUS select file a nursing complaint under the quick links.

- Bureau of Professional Licensing Complaint Form
- Treatment Data Form (If Applicable)
- Authorization for Release of Privileged/Client Information Form (If Applicable)
  - ➢ *To be signed by patient, his or her representative, or guardian if the patient is a minor*
  - ➢ *Samples of completed forms are included to assist you*

- ✓ Include the patient's date of birth and last 4 digits of their social security number, if applicable.

- ✓ Include all relevant documents that support your allegation.

- ✓ Please ensure all submitted documents are legible.

- ✓ If you are signing this release on behalf of a patient, who is not a minor child, you must provide us with a Letter of Authority, issued by the probate court, which empowers you to act on behalf of the patient.

- ✓ Upon submission of your information a determination will be made if an investigation can be initiated. You may also be contacted with a request for additional information or documentation.

If you have any questions in completing the enclosed forms, contact our office at (517) 241-0205.

You may submit your complaint by one of the following methods:

Mail:
Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
ATTN: Complaint Intake Section
611 W. Ottawa Street, PO Box 30670
Lansing, MI 48909-8170

E-Mail: BPL-Complaints@michigan.gov

FAX: (517) 241-2389

BPL/IID-200 (Rev. 2/24)

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division
P.O. Box 30670
Lansing, MI 48909-8170
(517) 241-0205

Office Use Only
File #:

COMPLAINT FORM

Authority: Public Act 368 of 1978, as amended
Completion: Voluntary Penalty: None

Please be advised this agency DOES NOT assist citizens seeking reimbursement or resolution of billing or fee disputes or investigate anonymous complaints. In addition, this agency DOES NOT handle complaints against health care facilities.

INSTRUCTIONS: Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the form to the address above. Please complete a separate form for each practitioner you are filing a complaint against.

Information About You		
Your Name		
Street Address		
City		
State	Zip Code	County
Patient's Name		
Patient's Date of Birth (MM/DD/YYYY)		
Patient's Last 4 Digits of Their Social Security Number		
Your Telephone Numbers Including Area Code Cell: Home: Work:		

Complaint Being Filed Against	
Practitioner's First and Last Name	
Street Address	
City	
State	Zip Code
Practitioner's Telephone Number	
Treatment/Incident Date	
Would you like to authorize a person other than yourself to communicate with the Department regarding your complaint? ☐Yes ☐No Name: Address: Telephone Number: Relationship to You:	

Check the profession for which you are lodging a complaint about:

- ☐Acupuncture
- ☐Athletic Trainer
- ☐Audiologist
- ☐Behavioral Analyst
- ☐Chiropractor
- ☐Counselor
- ☐Dentistry / Hygienists /Dental Asst.
- ☐Genetic Counseling
- ☐Marriage & Family Therapist
- ☐Massage Therapist
- ☐Midwifery
- ☐Nursing (RN, LPN)
- ☐Nursing Home Administrator
- ☐Occupational Therapist
- ☐Optometry
- ☐Pharmacist / Pharmacy Technician
- ☐Physician (M.D. or D.O.) Physician's Assistant
- ☐Physical Therapist
- ☐Podiatrist
- ☐Psychologist
- ☐Respiratory Therapist
- ☐Sanitarian
- ☐Social Worker
- ☐Speech/Language Pathologist
- ☐Veterinary Medicine

Are there civil actions pending?	Is there a police report?	May we release your name and this information to the practitioner?	Will you testify at an Administrative Hearing if necessary?
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Please provide details of your specific concerns related to the treatment rendered. Attach additional sheets if necessary.

☐ I authorize the Department to release my name, and all relevant information pertaining to this allegation, to other law enforcement agencies. I understand that I am under no obligation, whatsoever, to do so.

Your Signature	**Date**

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

BPL/IID-201 (Rev. 2/24)

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division

Office Use Only
FILE NUMBER:
~ SAMPLE ~

TREATMENT DATA FORM

NAME OF PATIENT: SMITH (LAST) MARY (FIRST) P. (M.I.)

Date of Birth: 01/01/1955 **Last 4 digits of Social Security Number:** 6780

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: JOHN DOE, M.D.
ADDRESS: 123 MAIN STREET
CITY/STATE/ZIP: LANSING, MI 48910
TELEPHONE: (517) 361-5858
Dates of Treatment:
Beginning: MAY 2017
Ending: SEPTEMBER 2018

FULL NAME: GOOD SAMARITAN HOSP.
ADDRESS: 789 FIRST STREET
CITY/STATE/ZIP: LANSING, MI 48912
TELEPHONE: (517) 361-5676
Dates of Treatment:
Beginning: AUGUST 24, 2018
Ending: AUGUST 31, 2018

FULL NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
TELEPHONE: _____
Dates of Treatment:
Beginning: _____
Ending: _____

FULL NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
TELEPHONE: _____
Dates of Treatment:
Beginning: _____
Ending: _____

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Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

BPL/IID-201 (Rev. 2/24)

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division

Office Use Only
FILE NUMBER:

TREATMENT DATA FORM

NAME OF PATIENT: ____
LAST FIRST M.I.

Date of Birth: ____________________ **Last 4 digits of Social Security Number:** ____________

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: ______________________________ **Dates of Treatment:**

ADDRESS: ______________________________ **Beginning:** ________________________

CITY/STATE/ZIP: __________________________ **Ending:** ________________________

TELEPHONE: ______________________________

FULL NAME: ______________________________ **Dates of Treatment:**

ADDRESS: ______________________________ **Beginning:** ________________________

CITY/STATE/ZIP: __________________________ **Ending:** ________________________

TELEPHONE: ______________________________

FULL NAME: ______________________________ **Dates of Treatment:**

ADDRESS: ______________________________ **Beginning:** ________________________

CITY/STATE/ZIP: __________________________ **Ending:** ________________________

TELEPHONE: ______________________________

FULL NAME: ______________________________ **Dates of Treatment:**

ADDRESS: ______________________________ **Beginning:** ________________________

CITY/STATE/ZIP: __________________________ **Ending:** ________________________

TELEPHONE: ______________________________

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

BPL/IID-202 (Rev. 2/24)

State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division
P.O. Box 30670
Lansing, MI 48909-8170

Office Use Only
FILE NUMBER: **~ SAMPLE~**

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, MARY SMITH, hereby authorize JOHN DOE, M.D.
(Patient/Client/Representative's Name) (Doctor/hospital/program or other custodian of record name)

1234 Main Street, Lansing MI 48910
(Address of doctor/hospital/program or other custodian of records)

To release/exchange information contained in the records of:

MARY SMITH	01/01/1955	6789
Patient's Name	Date of Birth	Last 4 digits of Social Security Number

1. **Name of person(s) or organizations(s) to whom disclosure is to be made**:
Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Professional Licensing, Investigations & Inspections Division, 611 W. Ottawa, P.O. Box 30670, Lansing, Michigan 48909-8170 or the Department of Attorney General.

2. **Specific type of information to be disclosed**:
Any and all **MEDICAL** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR, Part 2).

3. **The purpose and need for such disclosure**:
I understand that the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing and/or the Department of Attorney General may use any information and records so released in connection with the administration and enforcement of the laws of this State and of the United States.

4. I understand that if I give LARA permission I have the right to change my mind and **revoke** it. This must be in writing to: Privacy Office, Michigan Department of Licensing and Regulatory Affairs, Investigations and Inspections Division, 611 W. Ottawa St., Lansing, MI 48933. I also understand that LARA cannot take back any uses or disclosures already made with my permission. Unless otherwise revoked or if I fail to specify an expiration date, event or condition, this authorization will expire ONE (1) year from the signature date.

5. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

A copy of this authorization shall serve in the stead of the original.

Mary Smith — 1/14/2018
Patient/Client or Representative's Signature — **Date Signed**
(If signed by a Legal Representative, relationship to the Patient/Client. A letter of authority may be required)

Tim Smith — 1/14/2018
Witness' Signature — **Date Witnessed**

1/14/2018
Date Prepared

This authorization is acceptable to the Michigan Department of Licensing and Regulatory Affairs as compliant with HIPAA privacy regulations, 45 CFR, Parts 160 & 164, as modified December 11, 2003. If you need assistance with reading, writing, hearing, etc., under the American's with Disability Act, you may make your needs known to this Agency.

Completion: Voluntary Penalty: None Authority: P.A. 368 of 1978, as amended

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State of Michigan
Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division
P.O. Box 30670
Lansing, MI 48909-8170

Office Use Only
FILE NUMBER:

AUTHORIZATION FOR RELEASE OF PRIVILEGED/CLIENT INFORMATION

I, _____, hereby authorize _____
(Patient/Client/Representative's Name) (Doctor/hospital/program or other custodian of record name)

_____
(Address of doctor/hospital/program or other custodian of records)

To release/exchange information contained in the records of:

_____
Patient's Name Date of Birth Last 4 digits of Social Security Number

1. **Name of person(s) or organizations(s) to whom disclosure is to be made**:
   Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Professional Licensing, Investigations & Inspections Division, 611 W. Ottawa St., Lansing, Michigan 48933 or the Department of Attorney General.

2. **Specific type of information to be disclosed**:
   Any and all **MEDICAL** information that may have been obtained or made including, but not limited to, all medical records, alcohol, drug abuse and mental health records, billing records, pathology, radiology and laboratory reports, consents, authorizations or waiver forms, and any other documentation. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related Complex) and any other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR, Part 2).

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A copy of this authorization shall serve in the stead of the original.

_____ _____
Patient/Client or Representative's Signature **Date Signed**
(If signed by a Legal Representative, relationship to the Patient/Client.
A letter of authority may be required)

_____ _____
Witness' Signature **Date Witnessed**

_____
Date Prepared

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