

**FOR OFFICE USE ONLY:**

Date signed \_\_\_\_\_

Received \_\_\_\_\_

Docket Number \_\_\_\_\_

**VERMONT DEPARTMENT OF HEALTH  
BOARD OF MEDICAL PRACTICE  
108 Cherry Street, PO Box 70  
Burlington VT 05402-0070  
(802) 657-4220**

**COMPLAINT FORM**

**Please Print**

Your information

Last name \_\_\_\_\_ First name \_\_\_\_\_

Street address \_\_\_\_\_

City, State, Zip code \_\_\_\_\_

Business/daytime phone \_\_\_\_\_ Home phone \_\_\_\_\_

E-mail \_\_\_\_\_

This is a complaint against a \_\_\_\_\_ Physician (MD)

\_\_\_\_\_ Physician's Assistant (PA)

\_\_\_\_\_ Podiatrist (DPM)

Full name of Physician, Physician's Assistant or Podiatrist

\_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip code \_\_\_\_\_

Business phone of Physician, Physician's Assistant or Podiatrist \_\_\_\_\_

Name and location of health care facility (if known) \_\_\_\_\_

\_\_\_\_\_

**NATURE OF COMPLAINT:** Please describe, in detail, the nature of your complaint against this professional. Use the space on the reverse and additional sheets, if necessary.

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_



VERMONT DEPARTMENT OF HEALTH  
BOARD OF MEDICAL PRACTICE  
108 Cherry Street - PO Box 70  
Burlington, VT 05402-0070  
Toll free 800-745-7374  
Fax 802-657-4227

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**TO WHOM IT MAY CONCERN:**

**I HEREBY AUTHORIZE YOU** to furnish to the Vermont Department of Health, Board of Medical Practice, and/or its designated representative, and to the Office of the Attorney General, all medical records and all information, without reservation, within your possession or control pertaining to me, whether oral or written (including records provided to you by other health practitioners or health care institutions,) relating to any physical, psychiatric, mental or emotional condition or injury or disease for which you may have been consulted or for which you may have provided services.

Only in regard to this specific authorization for disclosure to the Vermont Department of Health, Board of Medical Practice, and to the Office of the Attorney General, and for no other purpose, I hereby expressly **WAIVE** confidentiality and/or any privileges or immunities accorded this information by State or Federal law, including materials covered by 42 CFR, Part 2, and I hold you harmless from disclosure of same to the Vermont Department of Health, Board of Medical Practice, pursuant to my request, to evaluate certain aspects of my health care.

**THIS AUTHORIZATION** is subject to revocation at any time except to the extent that you have already taken action in reliance on it. If not previously revoked, this authorization will terminate upon final action, including a judicial determination, of any action taken by the Board of Medical Practice that is related to this information, or, if no such action is taken, will terminate 365 days from the date hereof.

**YOU ARE ALSO AUTHORIZED** to report information, either orally or in writing, directly to the Vermont Department of Health, Board of Medical Practice, or its designated representative, and to the Office of the Attorney general, on a continuing basis until this authorization expires or is revoked.

**A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.**

Date \_\_\_\_\_

Name \_\_\_\_\_

Printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address

Date of Birth \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code