AUTHORIZATION AND CONSENT TO RELEASE OF INFORMATION

To Whom It May Concern:

I, the undersigned consent and authorize the release of information contained in **any health records** ***(including hospital records, physician office records, pharmaceutical prescription records and patient billing information)*** concerning the patient (s)

Print Full Name of Patient (s) _____

Patient's Health Card # ('s) _____

Patient's Date of Birth (s) _____

Print Full Name of Person Making Complaint _____

to the College of Physicians and Surgeons of Nova Scotia. This will also provide consent for the College of Physicians & Surgeons of Nova Scotia to request, receive, photocopy and disseminate this information as necessary for the investigation of the above complaint in accordance with the disciplinary process.

If the complainant is someone other than the patient <u>or</u> the patient's legally authorized representative, complete the following:

I hereby authorize _____ *to pursue this complaint*
(Print complainant's name)
on my behalf and to receive all information in relation to the investigation of the complaint.

If you are filing this complaint on behalf of the patient, please provide a copy of the documentation authorizing the complaint. Examples include: the Will naming you executor of estate, legal guardian, next of kin, patient's written consent, etc.

_____
Patient's Signature

<u>OR</u>

Legally authorized Representative*

_____
(Signature)

_____
(Print Name)

_____
Relationship to patient **(please state)**
(* includes: executor or administrator of an estate, next of kin or legal guardian)

_____
Date

_____
Name of Witness (print)

_____
Address

_____

_____
Phone Number

_____
Signature of Witness

_____
Date

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The College of Physicians & Surgeons of Nova Scotia

As the licensing and governing body for physicians in the province of Nova Scotia, the College takes your complaint seriously and will investigate it. Often the complaints process takes several months depending on the complexity of the complaint. If you are complaining about more than one physician, please complete a separate form for each. Additional forms may be obtained by calling 422-5823 or 1-877-282-7767, or you may photocopy this form.

The Complaints Process:

To begin an investigation into your complaint please

- **Complete this form (one form per physician)**
- **Ensure the consent form signature is witnessed**
- **Forward the completed forms to the College's Investigations Department**

If you have any questions or require assistance to complete this form, please contact the Investigations Department, at 422-5823 or 1-877-282-7767.

1. Patient information

Ms/Mrs/Mr/Dr _____ Address _____
Last Name _____ _____
Given Name _____ _____
Birth Date _____ Tel. Home _____
Health Card # _____ Tel. Work _____

2. Person making the complaint:

☐ **Same as Above (#1)**

OR

Relationship to patient _____
Ms/Mrs/Mr/Dr _____ Address _____
Last Name _____ _____
Given Name _____ _____
Tel. Home _____
Tel. Work _____

☐ **Please check this box if you want the College's final report sent to you via courier**

(If you are filing this complaint on behalf of the patient, please provide a copy of the documentation authorizing the complaint. Examples include: executor of an estate, legal guardian, the patient's written consent, etc.)

3. Consent for release of information.
(Inserted form)

Complete this form by providing the appropriate information and signatures. A witness is any adult person who can confirm that he/she saw you sign the form.

4. Print full name of the doctor complained about along with his/her address and telephone number.

Physician Name	Location (name of clinic or hospital where care was provided)	Telephone Number

5. How long have you been a patient of this doctor? _____

6. Have you brought your concerns to this doctor's attention? Yes __ No __
Please explain.

_____
_____
_____

7. Provide the full name of any other individual(s) and the details of the information they may have pertaining to your complaint (e.g., other doctor, therapist, chiropractor).

Name	Address	Information details

8. Provide full names of hospitals and dates you attended, related to your complaint, if applicable.

Name of Hospital	City	Date(s) attended

9. Have you brought your concerns to other authorities for investigation such as hospitals or law enforcement?

Yes __ No __ Please explain:

_____
_____
_____

10. Provide a clear description of the complaint you have about the doctor. Please explain in your own words an account of the incident in question. (Attach additional pages if necessary)
Please print or type your complaint.

I wish to lodge a formal complaint about Dr. (…)

_____ _____
Signature of person making complaint Date

_____ _____
Patient's signature Date

Please attach any relevant information that will assist our inquiry into this complaint.

COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA
Suite 400 – 175 Western Parkway
Bedford, NS B4B 0V1

Telephone: (902) 422-5823
Toll free in NS: 1-877-282-7767
Fax: (902) 422-5271

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