STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

ACUPUNCTURE BOARD
1747 North Market Boulevard, Suite 180, Sacramento, CA 95834
(916) 515-5200 FAX (916) 928-2204 www.acupuncture.ca.gov

CONSUMER COMPLAINT FORM

PLEASE PRINT OR TYPE

COMPLAINT REGISTERED AGAINST

Name:			Name of Acupuncture Clinic:
Address:			
City:	State:	Zip Code:	Office Phone Number:

PERSON REGISTERING COMPLAINT

Mr. ☐ Mrs. ☐ Ms. ☐	Name: Email:		Relationship to Patient:
Address:			Home Phone Number:
City:	State:	Zip Code:	Work Phone Number:
Patient Name:		☐ Male ☐ Female	Patient's Date of Birth:

Legal Authority to act on patient's behalf?

Has patient been examined or treated by another acupuncturist or health care professional for this same complaint?
YES ☐ NO ☐
If yes, please provide full names and addresses below.

DETAILS OF COMPLAINT

Dates of Visits:

State your complaint in detail (attach additional pages if necessary):

NOTICE: As much information as possible should be provided, in addition to any supporting documents pertaining to your specific complaint. Failure to provide sufficient information or documentation may prevent or delay the review of your complaint. The information will be used to determine whether a violation of law has occurred. If a violation is substantiated, the information may be transmitted to other governmental agencies, including the Office of the Attorney General.

Signature _____ Date _____

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SUPPLEMENTAL COMPLAINT INFORMATION

PLEASE PROVIDE THE NAME, ADDRESS, TELEPHONE NUMBER AND DATE OF VISIT TO ANY OTHER ACUPUNCTURISTS OR HEALTH CARE PROFESSIONALS YOU HAVE SEEN SINCE BEING TREATED BY THE SUBJECT OF YOUR COMPLAINT.

1.

NAME:
ADDRESS:
PHONE NO: DATE(S):

2.

NAME:
ADDRESS:
PHONE NO: DATE(S):

3.

NAME:
ADDRESS:
PHONE NO: DATE(S):

4.

NAME:
ADDRESS:
PHONE NO: DATE(S):

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AUTHORIZATION FOR RELEASE
CASE NUMBER:

- ☐ **Drug/Alcohol Treatment Records** **(Initial/Date)**_____
- ☐ **Medical or Acupuncture Records** **(Initial/Date)**_____
- ☐ **Psychiatric/Therapy/Counseling Records** **(Initial/Date)**_____
- ☐ **Physical Therapy Records** **(Initial/Date)**_____
- ☐ **Employment Records** **(Initial/Date)**_____
- ☐ **Other (Specify)** _____ **(Initial/Date)**_____

TO:

You are hereby authorized to mail to the State of California, Acupuncture Board, as identified by my initials/date and address above, any and all information you may have concerning any employment, illness, and injury, medical history, consultation, prescription, treatment, or report of any nature whatsoever, including, but not necessarily limited thereto, all hospital, medical, and billing reports relating to the treatment of:

Name: _____

Date of Birth: _____

Social Security Number or Medical Record Number _____

For the period of: _____

This authorization shall become effective immediately and shall remain in effect during the course of investigation and any criminal and/or administrative proceeding(s) arising out of the investigation.

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PURPOSE: This authorization is given with the understanding that this information and the records received will be used for official purposes only, including investigation and possible criminal and/or administrative proceedings regarding any violations of the laws of the State of California. I further understand that I have a right to receive a copy of this authorization, if I so request.

REVOCATION: This Authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor and others have acted in reliance upon this Authorization prior to the effective date of the written revocation, if any.

DISCLOSURE: I understand that the Requestor may not lawfully use or disclose any information/documentation obtained for any purpose other than that stated above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A COPY OF THIS AUTHORIZATION (INCLUDING A FAXED COPY) SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ _____

Signature of Patient/Person Authorizing Release **Date**

NOTE TO THE PROVIDER: Failure by a health care provider to provide the requested records within fifteen (15) working days of receipt of this request and authorization may be a violation of Section 123100 of the California Health and Safety Code and may result in a fine and disciplinary action.