Print the following form:

PATIENT EXPERIENCE RECORD

PLEASE NOTE: If the treating physician is not a HDNCMS member, our ability to be of service is limited but, in the interest of improving physician/patient relations, we will try to process your complaint. In all cases and even if your physician is a member of HDNCMS, the opinion of the Committee is advisory only. The HDNCMS has no power to require your physician to accept its advise.

This matter will be directed to the Society's appropriate committee for review at its next scheduled meeting. You will be advised when they have rendered an opinion. Completion of a review normally takes several weeks.

PLEASE PRINT:

PHYSICIAN NAME: _____

YOUR NAME:_____***ADDRESS:***_____

CITY:_____***STATE:***_____***ZIP:***_____***PHONE #***_____

DATE(S) OF TREATMENT:_____

Briefly state the problem:(Use the back of this page if necessary. Attach copies of bills or other pertinent documents. Do not send originals. Use black ink or typewriter only.)

Pursuant to Civil Code § 43.96 *"The Medical Board of California is the only authority in the state that can take disciplinary action against the license of the physician whom your complaint relates. The toll-free number of the Medical Board of California is (800)633-2322, and is located at 1426 Howe Ave., Suite 54 Sacramento, CA 95825–3236."*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____to furnish medical

information concerning_____(Patient) to :

HUMBOLDT–DEL NORTE COUNTY MEDICAL SOCIETY
PUBLIC SERVICE COMMITTEE
P.O. BOX 6457
EUREKA, CA 95502

Any and all information may be released, including but not limited to mental health records protected by the Lanterman–Petris–Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:_____
_____
_____

The information may be used only for the following purposes:
_____
_____
_____

this authorization is effective now and will remain in effect until_____(date).

I understand that I have the right to receive a copy of this authorization.

Signed:_____Dated:_____

If not signed by the patient, please indicate relationship:

( ) parent or guardian of minor patient (to the extent minor could not have consented to the care)
( ) guardian or conservator of an incompetent patient
( ) beneficiary or personal representative of deceased patient
( ) spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

HUMBOLDT-DEL NORTE COUNTY MEDICAL SOCIETY
P.O. BOX 6457
EUREKA, CA 95502
(707) 442-2367 / (707) 465-0980 (CC)