HUMBOLDT-DEL NORTE
COUNTY MEDICAL SOCIETY

P.O. BOX 6457 EUREKA, CA 95502
(707) 442-2367 / FAX: (707) 442-8134
E-MAIL: hdncms@gmail.com WEB: www.hdncms.org

I am writing to acknowledge your conversation today with my staff regarding the services rendered to you by one of our local physicians and/or their staff.

The Humboldt-Del Norte County Medical Society (HDNCMS) is a non-profit professional association of physicians dedicated to maintaining quality medical care and improving physician/patient relationships. The HDNCMS's Public Service and Medical Ethics Committee is a volunteer committee working toward this goal.

Thank you for assisting us in identifying potential problems which need to be brought to the attention of the committee for review. The Public Service and Medical Ethics Committee is interested in addressing patient complaints to assist us in our goals to improve services in our community and will attempt to mediate your complaint . However, we are required to advise that.....

"While the Humboldt-Del Norte County Medical Society will attempt to mediate any dispute, it has NO authority to take action against a physician's license," *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 2005 Evergreen Street #1200, Sacramento, CA 95815.*"

If you choose to refer your complaint to the Medical Board, the Medical Society must play a secondary role and defer to any decision by the board. The Public Service and Medical Ethics Committee will not review your complaint until the medical board completes their review.

If you wish the Medical Society's Public Service and Medical Ethics Committee to review your complaint, please complete the enclosed Patient Experience Record and Authorization For Release of Medical Information forms and return to our office. Please let us know if you have any objections to the physician knowing who the complaint is from.

Due to the time it takes to gather the necessary information to adequately review your complaint, it may take several weeks before a decision is reached. However, following the committee's review, you will be notified of its decision.

If the enclosed forms are not received within thirty (30) days, we will assume that the matter has been resolved and closed.

Please contact this office if you have any questions.

Sincerely,

Humboldt-Del Norte County Medical Society

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 advice.

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 2005 Evergreen Street #1200, Sacramento, CA 95815."*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____to furnish medical

information concerning_____(Patient) to :

HUMBOLDT–DEL NORTE COUNTY MEDICAL SOCIETY
PUBLIC SERVICE AND MEDICAL ETHICS 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)

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