Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

CENTRAL INVESTIGATIONS UNIT
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City, MO 65102-1335
Telephone: 573-526-0162
573-751-5649 FAX
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri
http://www.pr.mo.gov/realestate.asp

Don Eggen
Chief Investigator

To: Complainant

From: Don Eggen
Chief Investigator

Re: Explanation of Complaint System

This is in response to your request for a complaint packet.

When filing a complaint, be sure to explain your allegations thoroughly in written form and provide copies of any documents, letters, bills, etc. that support your complaint.

In order for the licensee to release any information regarding services provided to you by a health care practitioner the individual receiving the services must sign the enclosed release of confidential information form(s). The release form(s) must be returned with the complaint. If the form(s) are not returned or incomplete your complaint may be delayed.

The licensee will receive a copy of the complaint and release form(s) and will be instructed to respond to the complaint you have filed within thirty (30) days.

Upon receiving a response from the licensee, your complaint will be reviewed by the Investigative Unit to make sure all the requested paperwork is included in the complaint file. If additional information is required, you will be contacted. The licensing agency will then review the entire complaint and response.

You will be notified in writing of the results of this review. Please understand details relating to the investigation, such as the licensee's response, or statements made relating to the investigation and review process are confidential.

Please send the uniform complaint form, release of confidential information form(s), and all pertinent documents to the attention of Don Eggen, Chief Investigator, Division of Professional Registration, Post Office Box 1335, Jefferson City, MO 65102.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Patient: _____ Social Security No: _____ Date of Birth: _____

1. I authorize the use and disclosure of protected health information as described below; and,

2. Authorize and request: _____ (name of health care provider)

3. TO RELEASE THE FOLLOWING INFORMATION: any and all billing records; medical records charts; medical reports; chart notes; clinical notes; x-rays and/or radiographic studies and reports of the same; reports of consultation; patient histories/patient questionnaires; reports and records of laboratory testing and other testing; any and all correspondence (in any format) and any other records and documents contained in my file; or, if applicable, for each admission, whether In-Patient, Out-patient, or Emergency Room, the entire record for each admission, to include admitting history & physical; discharge summary; reports of consultation; reports and records of laboratory testing and other testing; reports of consultation; x-rays and radiographic studies and reports of the same; and other records and documents for each admission;

4. ☐ Covering all past, present, and future periods of health care; OR ☐ Covering the period of health care from _____ to _____.

5. The requested information is to be released to the **Central Investigations Unit of the Missouri Division of Professsional Registration (CIU)**, P.O. Box 1335, Jefferson City, MO 65102.

6. The requested information is to be used or disclosed for the purpose of oversight activities authorized by law, including audits; civil, administrative, or criminal investigations, inspections, licensure, or disciplinary proceedings or actions; or other activities necessary for the CIU or entities subject to government regulatory programs for which information is necessary for determining compliance with program standards.

7. This authorization shall be in force and effect and not expire until (a) I exercise my right of revocation, as described below, (b) the occurrence of the following date/event _____, or (c) one year from the date of execution, whichever occurs first. A photocopy of this authorization is as valid as an original.

8. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so by communicating in writing, with specific reference to this authorization, to the health care provider named in paragraph 2, above, and to the CIU. I understand that the revocation will not apply to information that has already been released in response to this authorization.

9. I understand that I may refuse to sign this authorization. I further understand that the health care provider named in paragraph 2 may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

10. I understand that after information is disclosed pursuant to this authorization, it is possible that the information may be redisclosed by the recipient and would no longer be protected by applicable medical privacy laws.

11. I understand that the information in the requested health record may include information relating to Hepatitis B or C, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). It may also contain information about behavioral or mental health services, psychiatric and/or psychological evaluation testing and/or treatment, and treatment for alcohol and drug abuse.

12. I understand that any information disclosed pertaining to alcohol/drug abuse is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of such information from making any further disclosure unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of such information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Patient, Parent/Guardian or Authorized Representative Date

_____ _____
Relationship to Patient Signature of Witness (optional)

STATE OF MISSOURI)
) SS.
COUNTY OF _____)

NOTARY (optional)

On the _____ day of _____, 20____, before me personally appeared the above-named Patient, Parent/Guardian, or Authorized Representative, known to me to be the person described in and who executed the foregoing instrument, and acknowledged that he or she executed the same as his or her free act and deed. In testimony thereof, I have hereunto set my hand and affixed my official seal, in the state and county aforesaid, the day, month, and year above written.

_____
Notary Public