STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
REGULATED INDUSTRIES COMPLAINTS OFFICE
CONSUMER RESOURCE CENTER
OAHU OFFICE
235 SOUTH BERETANIA STREET, 9TH FLOOR
HONOLULU, HI 96813
cca.hawaii.gov/rico

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FOR OFFICIAL USE ONLY

COMPLAINT FORM - HEALTHCARE PROFESSIONS

Important information about filing a complaint. RICO's jurisdiction is limited to violations of Hawaii's licensing laws and rules. Violations vary depending on the license type involved. As part of the review and investigation process, the company or individual you are complaining about may be informed of this matter and provided information about your complaint. Additional information about the industries RICO regulates, applicable licensing laws and rules, and a list of Frequently Asked Questions is available on the RICO website, as well as a fillable version of this and other RICO complaint forms.

If you want to report on-going unlicensed activity, please complete the Report of On-Going Unlicensed Activity form.

COMPLAINANT INFORMATION (Your information)

☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs.	*(Last Name)*	*(First Name)*	*(Middle Name)*

Your mailing address:

Telephone numbers (√ check best number to reach you at):

☐ Daytime phone: ( )

☐ Residence phone: ( )

Your email:

☐ Cellular phone: ( )

Are you filing on behalf of a business or organization? ☐ Yes ☐ No

If yes, please provide the name of your business/organization:

If someone is representing the COMPLAINANT, please complete this section.

_____ _____ _____
Representative's Name Mailing Address Phone No.

Representative's relationship to the COMPLAINANT: _____
If court appointed to assist the COMPLAINANT, please provide proof of legal guardianship.

Signature of COMPLAINANT authorizing RICO to work with representative: _____

Explain here if COMPLAINANT is unable to sign:_____

RESPONDENT INFORMATION
(Name of healthcare provider your complaint is against)
Please complete one complaint form per respondent.

Respondent: ☐ Business or ☐ Individual

Address:	Telephone No.: ( )
	Fax: ( )
Email:	Is the business or individual you are complaining about licensed? ☐ Yes ☐ No ☐ Don't know
Website address:	List any professional license number(s) here:

Names of people you dealt with:

DESCRIBE YOUR DISPUTE

Treatment date(s):

Please briefly explain your complaint (attach a separate sheet if necessary). If possible, include a ***timeline of events*** and ***approximate dates***.

If you have any of the following documents, please indicate by checking the box(es) and attaching **COPIES** of the documents. **Do not submit originals**; we are unable to return documents to you.

- ☐ Advertisements (flyers, brochures, newspaper or internet ads)
- ☐ Business cards
- ☐ Copies of correspondence (letters, emails, notes)
- ☐ Medical records (including notes, lab reports, x-rays)
- ☐ Opinions (including any independent medical examinations)
- ☐ Billing records
- ☐ Photos
- ☐ Other (please list) _____

☐ Check here if no attachments are included.

DID YOU ATTEMPT TO RESOLVE YOUR DISPUTE?

If your dispute involves a licensed business or individual, RICO recommends that you attempt to resolve your dispute with the licensee before filing a formal complaint. Please note unlicensed companies and individuals are not authorized to perform work that requires a license, therefore, RICO cannot recommend resolution of unlicensed complaints that involve additional or corrective work.

Have you reported your complaint to any other law enforcement or government agency? ☐ Yes ☐ No
If yes, please provide the following:

1) Name of the agency: _____
2) Approximate date when you filed your report or complaint: _____
3) Report or complaint number, if any: _____

Have you filed a lawsuit or other legal action (for example, mediation or arbitration) related to your dispute? ☐ Yes ☐ No
If yes, please provide the following:

1) Name of the court: _____
2) Case number, if any: _____
3) Attach **copies** of any relevant documents including any judgments or orders issued in the case.

ADDITIONAL QUESTIONS

Other agency referral: If upon review RICO believes a referral to another government agency is appropriate, do you consent to have your complaint sent to that agency for review? ☐ Yes ☐ No

If we are able to assist, what would your desired resolution be? Although our primary role is to enforce regulatory laws and rules, sometimes we are able to achieve some sort of resolution on the part of complaining parties. ***IF*** we are able to assist, what would your desired resolution be? (Again, as a government agency, RICO represents the State of Hawaii as a whole. We do not represent you in your dispute and strongly advise all consumers immediately explore any civil remedies they may have.)

CERTIFICATION

RICO requires complainants complete, sign, and certify below. We can assist you if you are unable to sign or otherwise complete this form. Knowingly submitting false or untrue information may constitute a violation of Hawaii Revised Statutes §710-1063.

I certify that all statements and attachments provided to RICO as part of this complaint are true and correct to the best of my knowledge.

I understand investigation and prosecution is at the discretion of the agency and that RICO does not represent me in this dispute.

Complainant's/Representative's signature:	**Date:**

Print name here: ☐ Check here if signing as representative

Profession or Area of Practice:

Acupuncture Practitioner
Athletic Trainer
Audiologist
Behavior Analyst
Chiropractor
Dentist/Dental Hygienist
Dispensing Optician
EMT/Paramedic
Hearing Aid Dealer/Fitter
Marriage/Family Therapist
Massage Therapist/Establishment
Mental Health Counselor
Naturopath
Nurse (RN, LPN, APRN)
Nursing Home Administrator
Occupational Therapist
Optometrist
Pharmacy/Pharmacist
Physical Therapist
Physician or Osteopath
Physician Assistant
Podiatrist
Psychologist
Respiratory Therapist
Social Worker
Speech Pathologist

DCCA Department of Commerce and Consumer Affairs
Regulated Industries Complaints Office

Mail completed complaint forms to:

Regulated Industries Complaints Office
Attention: Consumer Resource Center
235 South Beretania Street, 9th Floor
Honolulu, Hawaii 96813

Complaint forms are accepted at neighbor island RICO offices for mailing.

This material is available in alternate formats including large print.
For assistance, please contact the RICO Complaints and Enforcement Officer at 586-2666.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND MEDICAL INFORMATION

WHOSE records to be disclosed:

Name of Patient (Last, First, Middle):	Patient's Date of Birth:

Name of Patient or Person Signing Authorization Form on Behalf of Patient (Last, First, Middle):

I hereby authorize any treating health care provider, hospital, pharmacy or other facility to release the following records and information about the above-named patient to the Department of Commerce and Consumer Affairs' Regulated Industries Complaints Office ("RICO"):

(CHECK <u>ONE</u> – FORMS WITH MORE THAN ONE OPTION SELECTED WILL BE RETURNED)

☐ Records related to the admission and treatment for the following medical condition or injury: _____ _____ that occurred on or about: _____.

or

☐ Records for the following time frame: from _____ to _____.

or

☐ I am unable to recall specific treatment dates. Please disclose health information and records for the dates of any treatment received.

Records and information include:

(CHECK ALL THAT APPLY)

☐ **Mental Health Treatment Records** (Does not include psychotherapy notes)
☐ **HIV or AIDS related records**
☐ **Alcohol or drug abuse records** (*If you check this item, an additional authorization form will be sent to you*)
☐ **None** of the above

ADDITIONAL INFORMATION AND SIGNATURE OF THE PATIENT

Purpose of This Authorization: I understand that my records and information may be used to perform investigation, prosecution, and general oversight of health care practitioners as may be required under applicable state and federal laws, including but not limited to Hawaii's professional and vocational licensing laws. I understand that my records and information may also be used to perform investigation, prosecution, and general oversight over possible unlicensed activity that may be occurring in the State.

Term of This Authorization: I understand this Authorization is effective from the date signed until the conclusion of RICO's civil or administrative actions, including but not limited to any appeals or derivative matters or needs.

KEEP READING! AN ORIGINAL SIGNATURE IS REQUIRED ON THE BACK OF THIS FORM

Action Required to Revoke This Authorization: I understand I have the right to revoke this authorization by sending written notice to RICO at the above address. I understand any revocation will not apply to records or information already released or relied on by RICO in an action against a health care practitioner.

Redisclosure of Records and Information by RICO: I understand records and information obtained with this authorization may be redisclosed by RICO as part of RICO's investigation or prosecution of possible allegations related to my complaint, including to the health care practitioner that is the subject of a law enforcement or oversight matter and any attorney who may represent the practitioner; to an expert or consultant working for RICO or the health care practitioner; to a reviewing board, commission, or program, its personnel, and its authorized agents or other representatives; to the State of Hawaii Department of Commerce and Consumer Affairs Office of Administrative Hearings and its administrative personnel; to other law enforcement agencies with civil or criminal jurisdiction over matters relating to the protected health information; and to any other deliberative and/or reviewing bodies. I understand rediscloure to non-health oversight agencies may no longer be protected by federal privacy regulations.

I understand copies of this Authorization distributed by RICO shall be considered as effective as the original.

►_____ ►_____

(Original Signature of Patient) (Date)

COMPLETE THIS SECTION IF YOU ARE SIGNING ON BEHALF OF THE PATIENT

I certify I have authority to authorize the release of the above-named patient's medical records and information

- ☐ as the patient's custodial parent;
- ☐ as the patient's guardian;
- ☐ by legal power of attorney (copy of legal document demonstrating power of attorney must be attached); or
- ☐ as the patient's next of kin* (please describe _____).

I certify this information is true and correct to the best of my knowledge.

►_____ ►_____

(Original Signature of Patient Representative) (Date)

►_____

(Print Name of Patient Representative)

*Hawaii Revised Statutes section 622-57(c) permits a personal representative to obtain a decedent's medical records. If no personal representative exists, the decedent's next of kin in superseding priority is authorized to obtain the records in the order of adult child, parent, adult sibling, grandparent and guardian at the time of death. When there are multiple persons at the same level of superseding priority, all such persons shall be entitled to request and obtain the records. The person claiming to be next of kin of a deceased person and requesting the deceased person's medical records shall submit to the medical provider from whom the records are requested, an affidavit attesting to status as next of kin with superseding priority. The medical provider may rely upon the affidavit, and in so doing, shall be immune to any claims relating to release of the medical records.

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