STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

COMPLAINT

Please print or type

SUBJECT INFORMATION ***(Registered Nurse (RN), Applicant Or Unlicensed Person Claiming To Be An RN – Complete All Known Information.)***
Name ***(Last, First, Middle):*** **RN Number:**
Home Address ***(Number & Street):***
City: **State:** **Zip Code:**
Employer:
Business Address ***(Number & Street):***
City: **State:** **Zip Code:**
Home Phone: **Business Phone:**
Additional Information ***(Birthdate, Former Name, etc.):***

PERSON REGISTERING COMPLAINT
Name ***(Last, First, Middle):***
Address ***(Number & Street):***
City: **State:** **Zip Code:**
Home Phone: **Business Phone:**
Email:
Relationship to Nurse ***(*Patient, Coworker, Friend, etc.):***   ****If you are the patient or a patient's legal representative, please complete the attached Release Form***

DETAILS OF COMPLAINT **(*Who, What, Where, When, Why, How; Include Copy of Relevant Documents; List Any Witnesses & Telephone Numbers. Use "Tab" to continue on next page if additional room is necessary.)***

Your Signature **Date**

DETAILS OF COMPLAINT ***(Continued)***

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Fax: (916) 574-7796 or (916) 574-8629 | www.rn.ca.gov

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name	Date of Birth
Medical Record Number (If applicable)	Date of Death (If applicable)
BRN Case Number Sp. Investigator	Social Security No. (Optional)

I, the undersigned hereby authorize:

Physician/Facility _____

Address _____

City/State/Zip _____

Phone Number(s) _____

Treatment Date(s) _____

to disclose medical records, in the course of my diagnosis and treatment to the **CA Board of Registered Nursing,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and any possible proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Board of Registered Nursing at the above address. My written revocation will be effective upon receipt by the Board of Registered Nursing but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

Patient Signature_____ Date_____

or Legal Representative_____ Date_____

NOTE: 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. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.