Stanislaus Medical Society

PATIENT EXPERIENCE RECORD

In keeping with Civil Code 43.96, please be advised that while the Stanislaus Medical Society's Public Service Committee will review your concern and advise you of its finding, 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 may take disciplinary action against the license of the Physician to whom your complaint relates. The toll-free number of the Medical Board of California is (800)633-2322, and the Medical Board is located at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236. Please be advised that if you seek the advice, or have retained an attorney, the Stanislaus Medical Society's Public Service Committee will be unable to hear your complaint. The purpose of the Committee is to handle resolution of non-judicial matters."

The Stanislaus Medical Society (SMS) is a non-profit organization of physicians and surgeons, dedicated to maintaining quality medical care and improving patient relationships. SMS has a variety of committees volunteering their time toward these goals.

It is recommended that you personally discuss the issue with your physician before completing and returning this form. In most instances this communication resolves the problem.

If the treating physician is not an SMS member, our ability to be of service may be limited but, in the interest of improving patient relationships, we will still process your complaint. In all cases, even if the physician in questions is a member of the SMS, the opinion of the Committee will be advisory only. SMS has no power to require you or your physician to accept its advice.

ACTION: This matter will be directed to the proper committee for review. You will be advised when they have rendered an opinion. Please allow 6-12 weeks for completion of the review process.

Please download this form, complete the necessary information for our Review Committee. [please print or type] ***and return to the Stanislaus Medical Society at PO Box 576007, Modesto CA, 95357-6007.*** The more clearly you describe the situation or problem, the more effective the review can be.

Patient Name:	*Physician Name:*
Address:	*Address:*
City:	*City:*
Zip:	*Zip:*
Telephone:	*Telephone:*

PARENT OR GUARDIAN [if patient is less than 18 years old]

Name	*Address:*
City:	*Telephone:*

Please answer the following questions in detail.

1. What was the date you first felt there was a problem?

2. Have you contacted the physician in question? ☐Yes ☐No

   If yes, give date(s):

   Method used: ☐Telephone ☐Letter ☐Other, *please describe:*

3. Did the physician in question respond? ☐Yes ☐No

   If yes, what action was taken?

4. Have you ever been examined or treated by another physician relative to your problem? ☐Yes ☐No

   If yes, give full name of physician:

5. Have you voiced concern to any other agency or organization? ☐Yes ☐No

   If yes, please indicate to whom:

6. Have you contacted an attorney or filed a claim in Small Claims Court? ☐Yes ☐No

7. Can you suggest a fair solution to the problem?

   Briefly describe your concern(s). Please be specific; include all that you can remember about dates, places and names. Attach legible copies of all itemized bill and pertinent documents, if applicable to your complaint. If you need more space, you may attach additional sheets to this form. ***Please print clearly or type.***

AUTHORIZATION

For the purpose of reviewing the above-described matter, I _____, being the patient or legal guardian of same, hereby authorize _____MD/DO to release information relative to any diagnosis, treatment, prognosis, medical records, x-rays or other information which relates to the above-described matter to the Stanislaus Medical Society. I also authorize the Stanislaus Medical Society to release a copy of this form (Patient Experience Record) with any and all attachments to the physician in question. I understand this authorization will be valid until a date two (2) years after the date hereof. I certify that all information which I have given herein to be true correct and complete to the best of my knowledge.

Signature _____ Date _____

Authorization For Disclosure to and Use of Protected Health Information by the

STANISLAUS MEDICAL SOCIETY

As required by California law and the Health Information Portability and Accountability Act of 1996 (HIPAA), your physician may not use or disclose your individually identifiable health information without your authorization except as provided by California law and, if applicable, in the physician practice's Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby authorize the medical practice identified on the accompanying complaint to use and disclose health information concerning

_____

(*patient's name and address*) as follows:

Health information to be used or disclosed (check *only one box*):

☐ Any and all health information other than psychotherapy notes 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·

_____

_____

_____

☐ All psychotherapy notes may be released, except as specifically provided below·

_____

_____

_____

This health information may be disclosed to: Stanislaus Medical Society-PO Box 576007, Modesto, CA 95357

The information may be used only to investigate and attempt to resolve the accompanying complaint.

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law

Effect of Refusal to Sign Authorization. I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now and will remain in effect until the Medical Society has finished handling this grievance.

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

Signed. _____ Dated: _____

Print Name: _____

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