



HCMS
Harris County Medical Society

To Whom It May Concern:

To file a complaint concerning a member of the Harris County Medical Society, please complete the attached forms and forward to the address provided on the complaint form. It is very important that the information be legible; therefore, print or type the information onto the forms. If you prefer, you may type your statement on a separate sheet(s) and attach it to the form. *You may also send other supporting documents that are pertinent to your complaint.* Upon receipt in this office, your complaint will be forwarded to our committee for investigation. Please be sure you sign both the complaint form and the authorization for release of records. We must have your signature in order to proceed.

Please be aware all information sent to us **must** be presented to the subject physician to allow for a complete response to all the allegations. Do not send any information you do not wish the physician to view. You must submit the complaint in a format that both the subject physician and the Public Grievance Committee can review.

You will hear from the committee when the inquiry is completed, usually in about sixty days. We hope this service will be of assistance to you. Please understand the Public Grievance Committee was established in an effort to help resolve problems that may occur during the course of medical care. We do not have legal nor civil jurisdiction over physicians and do not have authority to restrict a physician's license or privileges.

Sincerely,

Peer Review Department
Public Grievance Committee

Enclosures as stated above

John P. McGovern Building
1515 Hermann Drive, Houston, TX 77004-7126
Phone: 713.524.4267 Fax: 713.942.7072
www.hcms.org

REQUEST FOR REVIEW OF PROFESSIONAL SERVICES
RENDERED BY A PHYSICIAN



HCMS investigative procedure only reviews services received in the last three year.

Name and Address of Physician

Telephone Number _____

Name and Address of Patient

_____ Age _____

Telephone Number _____

Name and Address
Of Complainant _____
(if other than patient) _____

Telephone Number: _____ Relationship to Patient: _____

Professional Service Provided From (date) _____ To _____

Describe the Issue for Which Review Is Requested _____

Have you discussed this complaint with your physician? Yes _____ No _____

How would you like to see the issue/problem resolved? _____

SUMMARY AND DETAILS OF CONCERN: (Please print or type)

Describe your complaint in detail and the events that led to your complaint. Include dates and location of the course of events. You may use additional paper and/or provide other documents to clarify the information given. ***This form must be signed in order to initiate a review.***

I have read the preceding, and it is true to the best of my information and belief.
If this issue can be more appropriately addressed by a different agency or society, I authorize HCMS to forward my concern to that agency or society.

Signature _____

Date _____

**Please complete and
mail to:**
Harris County Medical Society
Public Grievance Committee
1515 Hermann Drive
Houston, TX 77004-7126

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

Dear Dr. _____:

I, (patient name) _____, hereby authorize and request you and/or your practice, to disclose the protected health information described below.

The health information to be disclosed is indicated by the checkmark below:

- Complete Medical Record
- Medical Records from _____ to _____ only
- All medical records concerning the following condition:

This disclosure may be made by the office staff of this practice or any person the practice may designate.

The health information is to be disclosed to the:

Harris County Medical Society
Public Grievance Committee
1515 Hermann Drive
Houston, Texas 77004-7126

The purpose for this release is the Public Grievance Committee's review of a complaint I have filed. This authorization shall be in force and effective until the final resolution of that complaint.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Grievance Committee at the address above. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (If relevant)