Wyoming Board of Medicine

Serving the public and practitioners since 1905

130 Hobbs Avenue, Suite A • Cheyenne, WY 82002
Phone: 307-778-7053 • Fax: 307-778-2069 • Toll Free within state: 800-438-5784
Email: wyomedboard@state.wy.us • Website: http://wyomedboard.state.wy.us

Mark Gordon
Governor

Board of Medicine use only
Complaint No:_____

COMPLAINT AGAINST A WYOMING PHYSICIAN and/or PHYSICIAN ASSISTANT

Please print or type all information

Your Name: _____ Date: _____

1. Your Address:

_____
Street City/State Zip Code

Daytime Phone: _____ Evening Phone: _____

2. Your relationship to patient involved: (circle one)

Self Spouse Parent Child Sibling
Colleague Friend Guardian None Other: _____

3. Name of Patient: _____ Date of Birth: _____

4. Patient's Mailing Address and Telephone Number:

_____
Street or P.O. Box City/State Zip Code

Daytime Phone: _____ Evening Phone: _____

5. Full name of physician and/or physician assistant about whom you are complaining:

_____

6. Name and facility and address where treatment was delivered:

_____
Name Address City/State Zip Code

7. Dates of Treatment: From: _____ To: _____

8. If treatment involved a hospital, please provide the name and location of the hospital:

_____
Name Address City/State Zip Code

9. Date/s of hospitalization: From: _____ To: _____

10. Name of any other practitioner/s involved in this patient's treatment:

_____

11. Address of any other practitioner/s involved with this patient's treatment:

_____
Name Address City/State Zip Code

12. Please describe in as much detail as possible the nature of the illness or condition for which the Physician and/or Physician Assistant were utilized. Please attach additional pages, records, documents, etc., as necessary. You may use additional pages.

13. Please describe in as much detail as possible the facts and circumstances about which you are complaining. Also attach additional pages as well as any documentation, patient charts, etc. that may have bearing on this matter. Please be sure to include any efforts to resolve this matter prior to bringing it to the Board's attention:

Please complete the attached Authorization for Release of Medical Records form and attach any additional information you think may be relevant and mail to:

Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002
(307) 778-7053 – (800) 438-5784 (in Wyoming)

IMPORTANT NOTE: The Authorization for Release of Medical Records MUST be completed, notarized and returned to the Board of Medicine for your complaint to be reviewed!

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize
Please print name

_____
Name of Practitioner (Physician(s) and/or PA(s) about whom complaint is being made)

_____
Name of Hospital or Treatment Facility (if applicable)

_____
Name(s) of other treating Practitioner(s), Hospital(s) and/or Treatment Facility(ies) (if applicable)

TO RELEASE THE MEDICAL RECORDS AND ENTER INTO DISCUSSION ABOUT:

_____
Patient's Name

Covering period from _____ to _____

Relating to the patient's examination, diagnosis, treatment, billing and prognosis to the:

Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002

This authorization shall be considered valid from the date below until such time as the Board receives written notice that it has been revoked. Authorization for Release of Medical Records cannot be revoked if action has already been taken based on the authorization or if access to the records is otherwise authorized by law.

_____
Patient's Signature *Date*

OR

_____
Signature of authorized representative, parent or guardian (indicate legal relationship to Patient) *Date*

IMPORTANT: SIGNATURE *MUST* BE NOTARIZED!

County of _____)
) ss.
State of _____)

Subscribed and sworn to before me this _____ day of _____, _____.

_____
SEAL Notary Public

My commission expires: _____