



Please complete and return this form to:

**Complaint Reference Number:
Massachusetts Department of Public Health
Division of Health Care Quality
Complaint Unit
99 Chauncy Street, Boston, MA 02111-1212**

Name of Facility:

I, _____, hereby certified to the Department of Public
(your name)

Health, Division of Health Care Quality that I am entitled to receive confidential

information regarding _____, because:
(name of patient or resident)

(Please check the appropriate circle)

- I am the patient or resident named in the complaint. *(We apologize for our oversight in sending you this form in the event that it was not clear to us that the report you filed was regarding your own care or concerns. Thank you for clarifying this for us).*
- I am the parent of a child under 18 years of age who is the patient or resident names in the complaint.
- I am the court appointed legal guardian of the patient or resident named in the complaint under a current decree of guardianship.
- I am the activated health Care Proxy of the patient or resident named in the complaint investigation.
- I am the administrator or executor of the estate of the patient or resident named in the complaint.

Signature: _____ Date: _____

OR

- I have the written permission of the patient or resident named in the complaint

I, _____, give my permission to the Department
(name of patient or resident)

of Public Health to share confidential information contained in the Department's

complaint investigation report with _____
(name of person to receive a copy of the report)

Signature of Patient/Resident: _____ Date: _____