

 The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY

Governor

KIMBERLEY DRISCOLL

Lieutenant Governor

KATHLEEN E. WALSH

Secretary

ROBERT GOLDSTEIN, MD, PhD Commissioner

**Tel: 617-624-6000**

**www.mass.gov/dph**

**KNOW YOUR PATIENT RIGHTS**

The purpose of this form is to report any complaints **specifically related to the substance use disorder services** you receive during the time that you are incarcerated.

Records of your substance use disorder treatment are protected under federal law, including 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164. These records cannot be disclosed without your written consent unless otherwise provided for by law.

In order for BSAS to follow up on any complaints you have submitted, your consent is needed. You have the following options:

I authorize BSAS to use my information for this specific purpose to investigate my complaints. Please complete the release information completely on page 3.

**I do NOT authorize BSAS to use my information for this specific purpose.**

Please note that if you do not authorize BSAS to use your information, our ability to collect additional information needed to address your complaint may be limited.

Complaints can be submitted through the following ways:

**CONFIDENTIAL COMPLAINT LINE:**

(617) 624-5171

**MAILING ADDRESS:**

Quality Assurance and Licensing Unit - CIS

BSAS

Department of Public Health

250 Washington St. 3rd Floor

 Boston, MA 02108-4619

**CONFIDENTIAL FAX NUMBER:**

(617) 887-8787

For Internal Use Only

Complaint #: \_\_\_\_\_\_\_\_\_\_\_\_

Received by: Date:

**BSAS Complaint Form for Correctional Settings**

# Reporter Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reporter Contact information (if applicable): \_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reporter Type:** Incarcerated person/patient Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medication Service: Methadone Buprenorphine Vivitrol

# Clinical Service: Counseling Case Management Re-entry Services

**Address/Location of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Incident(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relevant Documents Attached: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Nature of Report**

 **Who was involved?**

 **What happened?**

#

#  Has a grievance been filed? If so, what actions have been taken?

#

# RELEASE OF INFORMATION

# Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorizes the Department of Public Health, Bureau of Substance Addiction Services (BSAS) to use the information reported above for the purpose of conducting an investigation related to the nature of the complaint related to the service provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (indicate the name of provider).

# This consent to release information can be revoked orally or in writing at any time, except to the extent that the information has been previously disclosed.

# This release is valid for the time period that BSAS requires to complete the investigation activities related to the complaint (not to exceed 3 years from the date below) or on this date \_\_\_\_\_\_\_\_\_\_\_as otherwise indicated by the patient.

# Signature of the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_