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

Created/Revised: November 2020, August 2023

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 _____