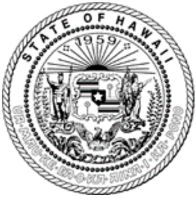


STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
REGULATED INDUSTRIES COMPLAINTS OFFICE
CONSUMER RESOURCE CENTER
OAHU OFFICE
235 SOUTH BERETANIA STREET, 9TH FLOOR
HONOLULU, HI 96813
cca.hawaii.gov/rico

_______-___________-__________-_____

FOR OFFICIAL USE ONLY

COMPLAINT FORM - LICENSED HEALTHCARE PROFESSIONS

Important information about filing a complaint. RICO's jurisdiction is limited to violations of Hawaii's licensing laws and rules. Violations vary depending on the license type involved. As part of the review and investigation process, the company or individual you are complaining about may be informed of this matter and provided information about your complaint. Additional information about the industries RICO regulates, applicable licensing laws and rules, and a list of Frequently Asked Questions is available on the RICO website, as well as a printable version of this and other RICO complaint forms. ***When completing this form, please print legibly or type.*** **Please complete one complaint form per respondent.**

COMPLAINANT INFORMATION (Your information)

☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs.	*(Last Name)*	*(First Name)*	*(Middle Name)*

Your mailing address:	Telephone numbers: (√ check best number to reach you at) ☐ Daytime phone: ( ) ☐ Residence phone: ( )
Your email:	☐ Cellular phone: ( )

Are you filing on behalf of a business or organization? ☐ Yes ☐ No

If yes, please provide the name of your business/organization:

If you are representing the COMPLAINANT, please complete this section.

_______________________________ _______________________________ ____________________

Representative's Name | Mailing Address | Phone No.

Your relationship to the COMPLAINANT: ____

If court appointed to assist the COMPLAINANT, please provide proof of legal guardianship.

Signature of COMPLAINANT authorizing RICO to work with representative: ______________________________

Explain here if COMPLAINANT is unable to sign:____

RESPONDENT INFORMATION
(Name of healthcare provider your complaint is against)

Respondent: ☐ Business or ☐ Individual

Address:	Telephone No.: ( )
	Fax: ( )
Email:	Is the business or individual you are complaining about licensed? ☐ Yes ☐ No ☐ Don't know
Website address:	List any professional license number(s) here:

Names of people you dealt with:

DESCRIBE YOUR DISPUTE

Treatment date(s):

Please briefly explain your complaint (attach a separate sheet if necessary). If possible, include a ***timeline of events*** and ***approximate dates***.

If you have any of the following documents, please indicate by checking √ box and attaching **COPIES** of the documents.
Do not submit originals; we are unable to return documents to you.

- ☐ Advertisements (flyers, brochures, newspaper or internet ads)
- ☐ Business cards
- ☐ Copies of correspondence (letters, emails, notes)
- ☐ Medical records (including notes, lab reports, x-rays)
- ☐ Opinions (including any independent medical examinations)
- ☐ Billing records
- ☐ Photos
- ☐ Other (please list) ______________________________

☐ Check here if no attachments are included.

DID YOU ATTEMPT TO RESOLVE YOUR DISPUTE?

If your dispute involves a licensed business or individual, RICO recommends that you attempt to resolve your dispute with the licensee before filing a formal complaint. Please note unlicensed companies and individuals are not authorized to perform work that requires a license, therefore, RICO cannot recommend resolution of unlicensed complaints that involve additional or corrective work.

Have you reported your complaint to any other law enforcement or government agency? ☐ Yes ☐ No
If yes, please provide the following:

1) Name of the agency: ______________________________
2) Approximate date when you filed your report or complaint: ______________________________
3) Report or complaint number, if any: ______________________________

Have you filed a lawsuit or other legal action (for example, mediation or arbitration) related to your dispute? ☐ Yes ☐ No
If yes, please provide the following:

1) Name of the court: ______________________________
2) Case number, if any: ______________________________
3) Attach **copies** of any relevant documents including any judgments or orders issued in the case.

ADDITIONAL QUESTIONS

Other agency referral: If upon review RICO believes a referral to another government agency is appropriate, do you consent to have your complaint sent to that agency for review? ☐ Yes ☐ No

If we are able to assist, what would your desired resolution be? Although our primary role is to enforce regulatory laws and rules, sometimes we are able to achieve some sort of resolution on the part of complaining parties. ***IF*** we are able to assist, what would your desired resolution be? (Again, as a government agency, RICO represents the State of Hawaii as a whole. We do not represent you in your dispute and strongly advise all consumers immediately explore any civil remedies they may have.)

CERTIFICATION

RICO requires complainants complete, sign, and certify below. We can assist you if you are unable to sign or otherwise complete this form. Knowingly submitting false or untrue information may constitute a violation of Hawaii Revised Statutes §710-1063.

I certify that all statements and attachments provided to RICO as part of this complaint are true and correct to the best of my knowledge.

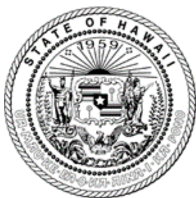
I understand investigation and prosecution is at the discretion of the agency and that RICO does not represent me in this dispute.

Complainant's signature:	**Date:**

Print name here: ☐ √ check here if signing as representative

Profession or Area of Practice:

Acupuncture Practitioner	EMT/Paramedic	Nursing Home Administrator	Podiatrist
Athletic Trainer	Hearing Aid Dealer/Fitter	Occupational Therapist	Psychologist
Audiologist	Marriage/Family Therapist	Optometrist	Respiratory Therapist
Behavior Analyst	Massage Therapist/Establishment	Pharmacy/Pharmacist	Social Worker
Chiropractor	Mental Health Counselor	Physical Therapist	Speech Pathologist
Dentist/Dental Hygienist	Naturopath	Physician or Osteopath	
Dispensing Optician	Nurse (RN, LPN, APRN)	Physician Assistant	



Mail completed complaint forms to:

Regulated Industries Complaints Office
Attention: Consumer Resource Center
235 South Beretania Street, 9th Floor
Honolulu, Hawaii 96813

Complaint forms are accepted at neighbor island RICO offices for mailing.

This material is available in alternate formats including large print.
For assistance, please contact the RICO Complaints and Enforcement Officer at 586-2666.

DAVID Y. IGE
GOVERNOR

DOUGLAS S. CHIN
LIEUTENANT GOVERNOR

CATHERINE P. AWAKUNI COLÓN
DIRECTOR
DEPARTMENT OF COMMERCE AND
CONSUMER AFFAIRS

DARIA A. LOY-GOTO
COMPLAINTS AND
ENFORCEMENT OFFICER

STATE OF HAWAII
REGULATED INDUSTRIES COMPLAINTS OFFICE
CONSUMER RESOURCE CENTER
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
LEIOPAPA A KAMEHAMEHA BUILDING
235 SOUTH BERETANIA STREET, 9TH FLOOR
HONOLULU, HAWAII 96813
FAX: (808) 586-2670
TELEPHONE: (808) 586-2653
cca.hawaii.gov/rico

HILO OFFICE
120 PAUAHI STREET, SUITE 212
HILO, HAWAII 96720

KONA OFFICE
HUALALAI CENTER
75-170 HUALALAI ROAD, ROOM C-309
KAILUA-KONA, HAWAII 96740

MAUI OFFICE
1063 LOWER MAIN STREET, SUITE C-216
WAILUKU, HAWAII 96793

KAUAI OFFICE
3060 EIWA STREET, SUITE 204
LIHUE, HAWAII 96766

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION AND RECORDS

IMPORTANT: THIS AUTHORIZATION DEALS WITH THE RELEASE, SHARING, DISCLOSURE, AND RECEIPT OF INFORMATION FROM YOUR MEDICAL AND HEALTH CARE RECORDS. READ IT CAREFULLY.

You must complete each section where there is an arrow ► symbol

I, ►________________________________ , of ►____________________________________
(Patient or Patient's Personal Representative) (Address)

►________________________________ ►____________________________________
(Date of Birth) (City, State, Zip code)

hereby authorize any health plan, physician, health care practitioner, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to (Patient Name) ►________________________________ to release, disclose and furnish copies of the following medical and health care information regarding my care and treatment to Regulated Industries Complaints Office, its agents and/or its attorneys (hereinafter referred to as "RICO").

By checking below, I authorize access and limit the authorization to the records described below **(PLEASE CHECK ONE ONLY):**

☐ Records regarding admission and treatment for the following medical condition or injury:

__________________________________ on or about ____________________________
(Condition or Injury) (Date of Service)

☐ Records from the period from ______________________ to ________________________

☐ Records confined to the following specified information:____________________________

☐ I am unable to recall specific treatment dates. Please disclose health information and records for the dates of any treatment I received.

(OVER)

By **initialing** below, I also authorize release of the following portions of the health care records/information.

_____ Mental Health Treatment Records (NOTE: This authorization does not include psychotherapy notes)

_____ HIV or AIDS related records

_____ Alcohol or drug abuse records (NOTE: Applicable only if substance abuse records are disclosed. The information disclosed includes records protected by federal confidentiality rules 42 CFR, part 2. The rules prohibit recipients of such records from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. The general authorization for the release of medical or other information is NOT sufficient for this purpose). If you initial this item, we will send you an additional authorization form to sign.

Term of Authorization: This Authorization is effective from the date I have signed it until the conclusion of RICO's civil or administrative actions, including but not limited to any appeals and any derivative matters or needs.

Revoking the Authorization: I have been advised that I have the right to revoke this authorization by contacting RICO in writing to request that this authorization be cancelled. If I revoke this authorization, the revocation will not apply to records or information that have been released before I notified the record keeper or RICO in writing of my change of mind, and will not apply to records that RICO has relied upon in taking action against a health care practitioner. I understand that my decision to revoke this authorization may impair RICO's ability to investigate a complaint and to pursue disciplinary action against a health care practitioner, and my complaint may be dismissed.

Redisclosure: I understand that the information used and disclosed in accordance with this authorization may be subject to redisclosure by RICO and may no longer be protected by the federal privacy rule. For example, RICO may disclose my records/information to the health care practitioner that is the subject of a law enforcement or oversight matter relating to my health information or his or her attorney; or to a consultant working for RICO or the health care practitioner. My records/information may also be disclosed to me, RICO's personnel, authorized agents or other representatives; any reviewing board, commission, or program; its personnel, authorized agents or other representatives; reviewing Advisory Committee Members and experts retained by RICO; the State of Hawaii Department of Commerce and Consumer Affairs Office of Administrative Hearings and its administrative personnel; other law enforcement agencies with civil or criminal jurisdiction over matters relating to the protected health information; and any other deliberative and/or reviewing bodies.

Purpose of disclosure: I understand that a number of state licensing boards including the Board of Medical Examiners of the State of Hawaii issues licenses to provide health care in the State of Hawaii. RICO, on behalf of the various boards, investigates complaints or reports regarding health care practitioners including physicians and physician assistants in order to determine whether disciplinary or other legal action is needed in order to protect patients and the public interest. I understand that my records and information may be used to perform investigation, prosecution and oversight of health care practitioners as may be required under applicable state and federal laws, including but not limited to the state's professional and vocational licensing laws. A photocopy of this authorization shall be considered as effective and valid as the original.

►____ ►__________________

(Signature of Patient or Patient's Personal Representative) (Date)

►____

(Print Name of Patient or Patient's Personal Representative)

If applicable, please describe how you are authorized to act as the Personal Representative of the Patient **(and attach verification of authority).**

____

Authorization Form Rev. 2/5/18