California State Board of Pharmacy 2720 Gateway Oaks Drive, Suite 100 Sacramento, CA 95833 Phone: (916) 518-3100 Fax: (916) 574-8614 www.pharmacy.ca.gov Business, Consumer Services and Housing Agency Department of Consumer Affairs Gavin Newsom, Governor



CONSUMER COMPLAINT FORM

NOTICE: The information included on the complaint form is requested per section 129 and section 4008 of the Business and Professions Code. All information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. The information on the complaint form will be used in part to determine whether a violation of state pharmacy law has occurred. If a violation is confirmed, the information may be transmitted to other government agencies, including the Attorney General's Offices.

PLEASE PRINT OR TYPE AND PROVIDE ALL THE REQUESTED INFORMATION.

Email address:					
	egistering the complaint:				
Address:					
City:	County:	State:	Zip Code:		
Work phone numb	per:	Home phone number:			
	tient:				
Name of pharmac	y:				
	,				
City:	County:	State:	Zip Code:		
Name of any othe	r person involved:				
When did the prob	blem occur?				

DETAILS OF COMPLAINT

Describe the events in the order they happened, as simply as possible.

Use extra sheets if necessary.

Have you discussed this matter with the pharmacist?	□ Yes	□ No
Name of person contacted:		
How? By phone By letter		
Result of contact:	-	
Further information (complete only if applicable)		
Prescribing doctor name:		Telephone:
Address:		
Medication prescribed:		Prescription number:
Medication received:		
The Prescription Was for a new medication Was a refill Was a new prescription for a medication that had bee Was there any harm to the patient? Yes Brief description:	n taken or use o Patio	d previously ent birthdate:
Did the pharmacist consult with you regarding your med No Was any of the medication take or used?		time it was dispensed?
Do you still have the medication take of used.		
Do you still have the container/label/receipt? \Box Ye		0
Are you the patient? \Box Yes \Box No If no		
What is your relationship to the patient?	,	
Are you the legal guardian of the patient?	□ No	
IF YOU HAVE THE MEDICATION AND/OR CONTAINER, PI	LEASE RETAIN	THEM UNTIL FURTHER NOTIFIED BY A
BOARD INSPECTOR.		
IF APPLICABLE, PLEASE ATTACH TO THIS FORM <u>COPIES</u> (bills/invoices received, canceled checks, correspondence		

Signature

Date

PLEASE COMPLETE THE ATTACHED MEDICAL RELEASE FORM AND RETURN WITH THE CONSUMER COMPLAINT FORM.

INFORMATION COLLECTION, ACCESS AND DISCLOSURE

The information you provide on this complaint form is maintained by the Executive Office of the Board of Pharmacy, 2720 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833. The information is requested pursuant to Business and Professions Code Sections 325 and 326.

Submission of all information requested is voluntary. However, please be aware omission of any information may result in your complaint being rejected as incomplete.

Your completed complaint form becomes the property of the Board and will be used by authorized personnel as appropriate. Information concerning your complaint may be transferred to other governmental or law enforcement agencies.

You have the right to review the records maintained on you by the Board unless the records are exempt by section 1798.40 of the Civil Code. You may gain access to the information by contacting the Board at the above address.



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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(Complainant/Patient)

_____, hereby authorize

(Person or entity and telephone number from which information may be obtained)

to disclose all records and information and answer any questions pertaining to the diagnosis and course of my treatment to the Board of Pharmacy (Board) and its representatives, including, but not limited to, investigators and legal staff, upon their request. I further agree to allow the Board and its representatives to process and possibly file an administrative action based upon my complaint against:

(Person/business being complained about – include license/registration number if known)

I understand that this information will be maintained in confidence and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of state and/or federal laws and regulations. I further agree that the Board and its representatives may release any and all of my records and treatment information to any other government agency which requests, or has been provided with, such information as part of an investigation into other possible violations of state and/or federal laws and regulations. This authorization shall be valid until completion of an investigation and prosecution, including any investigation and proceeding by another governmental agency that has requested, or been provided with, your records and information.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Complainant/Patient Signature

Date

OR

Complainant's/Patient's Representative and Relationship

Date

*Date of birth is needed to positively establish the identity of the patient