

# COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN

## COMPLAINT REPORTING FORM

As the licensing and governing body for physicians in the Province of Saskatchewan, the College takes your complaint seriously. All complaints are reviewed. Review of a complaint may take several months.

### The Complaints Process:

To begin the formal review process of your complaint, please:

- \_ **Complete this form and the Authorization form.**
- \_ **Forward the completed forms to the College.**

Upon receipt of the completed forms, the College will:

- \_ Provide the physician(s) complained about with a copy of the written complaint.
- \_ Contact those individuals/institutions who may have information relevant to the complaint.
- \_ Review all information.

Following the review, the College will:

- \_ Inform the complainant and the physician(s) in writing of the results of the review.

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### 1. Patient Information:

Ms. / Mrs. / Mr. (circle one)	Address _____
Last Name _____	Town/City _____
Given Name _____	Postal Code _____
Birth Date _____	Telephone (home) _____
Hospitalization Number _ _ _ _ _	Telephone (work) _____

### 2. If not the patient, information from the person making the complaint:

Ms. / Mrs. / Mr. (circle one)	Address _____
Last Name _____	Town/City _____
Given Name _____	Postal Code _____
Relationship to Patient _____	Telephone (home) _____
_____	Telephone (work) _____









## AUTHORIZATION FOR RELEASE OF INFORMATION

### IF YOU ARE THE PATIENT:

I understand my signature to this release will allow the College of Physicians and Surgeons of Saskatchewan to:

- 1) Obtain any medical records or other information relevant to the complaint;
- 2) Provide a copy of the letter of complaint and any pertinent information to the physician(s) named in the complaint;
- 3) Allow any authority that holds medical records relevant to my complaint to release such records to the physician(s) named in the complaint in order to allow those physicians to respond to that complaint.

\_\_\_\_\_  
(Print Patient's Full Name)

\_\_\_\_\_  
(Patient's Date of Birth)

\_\_\_\_\_  
(Patient's Hospitalization Number)

\_\_\_\_\_  
(Signature of Patient/Complainant)

\_\_\_\_\_  
(Date)

### THIRD-PARTY COMPLAINT - Complete ONLY if you are NOT the patient or NOT the parent of a young child.

The patient **may** authorize the complainant (the person making the complaint) to receive information:

I, \_\_\_\_\_, am aware of the complaint made to the College on my behalf,  
(print patient's name)

and authorize \_\_\_\_\_ to receive medical information with respect to  
(print name of person making complaint)

the review of this complaint.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

### IF THE PATIENT IS DECEASED:

Privacy rights for deceased patients continue after death unless one of the exceptions stated in Section 27(4)(e) of *The Health Information Protection Act* (HIPA) applies.

When the complaint relates to circumstances surrounding the death of the patient or services recently received by the patient, this section of HIPA permits the College to disclose relevant information to a member of the patient's immediate family or to anyone else with whom the patient had a close personal relationship.

\_\_\_\_\_  
(Relationship to patient)

\_\_\_\_\_  
(Signature of complainant)