State of Tennessee
Office of Investigations

Tennessee Department of Health
Office of Investigations
Heritage Place, Metro Center
227 French Landing, Suite 201
Nashville, TN 37243

Phone (615) 741-8485
TN Toll Free 1-800-852-2187

ALLEGATIONS REPORT

COMPLAINANT	**NAME (*FIRST, MIDDLE, LAST)***		**HOME PHONE** ( )
	BUSINESS NAME (*IF APPLICABLE*)		**WORK PHONE** ( )
	STREET ADDRESS		**CELL PHONE** ( )
	CITY/COUNTY	**STATE**	**ZIP**
NAME OF PATIENT (if other than yourself)	**NAME (*FIRST, MIDDLE, LAST)***		**HOME PHONE** ( )
	BUSINESS NAME (*IF APPLICABLE*)		**WORK PHONE** ( )
	STREET ADDRESS		**CELL PHONE** ( )
	CITY/COUNTY	**STATE**	**ZIP**
RELATIONSHIP TO PATIENT	**( ) PATIENT ( ) FAMILY MEMBER Specify:**		**( ) LEGAL GUARDIAN ( ) FRIEND**
	( ) EMPLOYER (attach copies of internal investigation and drug screens)		**( ) OTHER Specify:**

SUBJECT OF REPORT (*PRACTITIONER*)	**NAME (*FIRST, MIDDLE, LAST*)**		**PROFESSION: (Dr., Dentist, RN, etc.)**
	BUSINESS NAME (*IF APPLICABLE*)		**LICENSE NUMBER, IF KNOWN**
	STREET ADDRESS		**WORK PHONE** ( )
	CITY/COUNTY	**STATE**	**ZIP**

DETAILS OF COMPLAINT

DETAILS OF COMPLAINT	Please write legibly. Use a separate report form for each individual practitioner. Provide pertinent information such as: the sequence of events surrounding your concern in chronological order (by date), the names of witnesses, and copies of documents regarding your report (contracts, reports, or photographs). **Note: All materials received in connection with this report become the property of the Department of Health and cannot be returned.**

WITNESSES

NAME	ADDRESS	PHONE NUMBER
		( )
		( )
		( )
		( )

PLEASE RETURN TO:
Office of Investigations
Heritage Place, Metro Center
227 French Landing, Suite 201
Nashville, TN 37243

I have read the above and it is true to the best of my knowledge.

SIGNATURE _____ **DATE** _____

State of Tennessee
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Authorization for Release of Patient Information

TO: Any and all treating physicians and facilities

I, the undersigned, hereby authorize any and all licensed health care practitioners (including but not limited to physicians, psychiatrists, psychologists, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, emergency medical attendants) and others who have participated in providing any care or service to me to discuss any communication, whether confidential or privileged, and to provide **full** and **complete** patient reports and records, including but not limited to patient histories, x-rays, examination and test results, reports, or records to the **Tennessee Department of Health, Office of Investigations** (or any official representative of that Office) for investigation, reproduction, or other use.

I, the undersigned, am also fully aware that the communications and records of such communications, between myself and a health care practitioner may be by law "privileged" and that as such they can only be disclosed or released with my knowing and voluntary consent to waive the privilege I hold as to those communications and/or records. I hereby knowingly and voluntarily waive the privilege I hold as to any and all communications and records those providers have regarding the care and services I have received from them or members of their staff.

_____
Date

_____
Patient Signature

_____
Date of Birth

_____
Social Security Number

If patient is a minor or otherwise lacks capacity to sign:

_____ _____
Authorized Person Other Than Patient Relationship

{**Note**: If acting in capacity of legal guardian, attach copy of Power of Attorney, or other legal document.]

If you are the patient/legal guardian, this form must be completed in its entirety, in order for your complaint to be processed.