Iowa Board of Nursing
Enforcement Unit

Iowa Board of Nursing
400 SW 8th Street, Suite B
Des Moines, IA 50309-4685

Phone 515-281-6472
Fax 515-281-4825
Website nursing.iowa.gov

COMPLAINT FORM

Please print or type

NURSE BEING REPORTED		
Name (Last, First, Middle):		License Number:
Home Address (Number & Street):		
City:	State:	Zip:
Employer:		
Business Address (Number & Street):		
City:	State:	Zip:
Home Phone:	Cell Phone:	Business Phone:
Additional Information (Birthdate, Former Name, E-mail Address, etc.):		

PERSON REGISTERING COMPLAINT		
Name (Last, First, Middle):		
Address (Number & Street):		
City:	State:	Zip:
Home Phone:	Cell Phone:	Business Phone:
Email Address:		
Relationship to Nurse: (Please circle) **Employer Patient Coworker Friend Other: Explain_____** *If you are the patient, please complete the attached Release Form		

Go to next page for the details of the complaint.

DETAILS OF COMPLAINT: Please write legibly. Use a separate report form for each individual. Provide pertinent information such as: the chronological order of events, names of witnesses and telephone numbers, copies of documents relevant to the situation being reported.

I certify that all the information that I have provided herein is true and correct to the best of my knowledge.

_____ _____

Your Signature Date

PLEASE RETURN TO: Iowa Board of Nursing
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name_____Birthdate_____

Address_____

I, the undersigned do authorize and request_____
(Name of Health Care Provider)
To release to the Iowa Board of Nursing, 400 SW 8th Street, Suite B, Des Moines, IA 50309-4685.

This information is being disclosed and may be used only for the purpose of CONFIDENTIAL INVESTIGATION.

I agree that_____may release the following information from these medical records:
(Name of Health Care Provider)

[ ] History & Physical [ ] Discharge Summary [ ] Social History
[ ] Consultation [ ] Lab, X-ray, EKG [ ] Treatment Status
[ ] Other (please specify)_____
[ ] As much information as_____, in its full discretion.
(Name of Health Care Provider)

deems reasonably necessary for the purposes set forth by me for release.

This authorization is effective for_____from the date on which it is signed.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to The Iowa Board of Nursing and the above named Health Care Provider.

I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by

_____.
(Name of Health Care Provider)

PROHIBITION ON REDISCLOSURE	I acknowledge that the information to be released may include material that is protected by the state and/or federal law applicable to either mental health and/or drug/alcohol abuse or both. My signature authorizes release of all such information as specified above.
This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal Law for Alcohol/Drug Abuse Records or by State Law for Mental Health Records, Federal Requirements (42 C.F.R. Part 2) and State Requirements (Iowa Code ch.228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or Criminal penalties may attach for unauthorized disclosure of Alcohol/Drug Abuse or Mental Health Information.	_____ (Signature of Patient of Patients Authorized Representative) _____ (Relationship of Authorized Representative)