ALAMEDA-CONTRA COSTA MEDICAL ASSOCIATION

6230 CLAREMONT AVE. ● P.O. BOX 22895 ● OAKLAND, CA 94609-5895 ● TEL 510/654-5383 ● FAX 510/654-8959

COMPLAINT FORM

The Alameda-Contra Costa Medical Association (ACCMA) is a non-profit, private organization of physicians dedicated to maintaining quality medical care and good physician-patient relationships. The ACCMA has a variety of committees volunteering their time toward these goals. We encourage you to discuss this matter with your physician before submitting this form to the ACCMA. Such discussions generally resolve most problems. If the treating physician is not a member of the ACCMA, our ability to be of service will depend upon the willingness of the physician to participate in our process.

Please note that the Medical Board of California is the only authority in the state that may take disciplinary action against the license of the physician to whom your complaint relates. The toll-free phone number of the Medical Board is 800/633-2322, and the Medical Board is located at 1426 Howe Avenue, Suite 54, Sacramento, California 95825-3236.

If you have already contacted your physician and are unable to resolve this matter, by completing and signing this form, you agree to voluntarily participate in our review process. A copy of your complaint will be sent to your physician and this matter will be directed to the proper committee for review. This process takes approximately eight weeks. You will be notified in writing of the committee's opinion, which is advisory only.

Patient's Name ______________________ Doctor's Name ______________________

Address ______________________ Address ______________________

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Telephone ______________________ Telephone ______________________

Authorization: For the purpose of reviewing the dispute as stated below, I hereby authorize the doctor whose name I have written above to testify as to and to reveal any diagnosis, treatment, prognosis, medical records, x-rays, or other information which concerns me and relates to the dispute described below to the ACCMA. (Disputes will not be reviewed with out the patient's signature). I also authorize the ACCMA to release a copy of this form with any and all attachments to the above-named physician. This authorization shall be valid until a date two years after the date hereof.

Patient's Signature ______________________ Date ______________________

Please state your complaint briefly and attach photocopies of any billings or correspondence to which you refer below (do not send originals). Your complaint must be typed, or printed clearly in black ink only.

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