

COMPLAINT REGISTRATION

MINNESOTA BOARD OF PHYSICAL THERAPY
2829 UNIVERSITY AVENUE SE, SUITE 420
MINNEAPOLIS, MN 55414-3245
612-627-5406
MN Relay Service for Hearing Impaired 800-627-3529

NOTICE OF RIGHTS UNDER MINNESOTA DATA PRIVACY ACT

I understand that I am not legally required to complete or return this form. It is offered so that the Board may properly and thoroughly evaluate and investigate this complaint and if necessary, submit the information in any legal proceeding. Recognizing the Board's need to verify and, if necessary, legally pursue this complaint, I authorize the Board, its agents, and/or agents of the Attorney General's Office representing the Board to disclose this information to those whom they reasonably believe have a need to know.

YOUR NAME, ADDRESS, AND TELEPHONE NUMBER

NAME:

STREET ADDRESS:

CITY, STATE, ZIP:

HOME PHONE:

WORK PHONE:

NAME OF THE PHYSICAL THERAPIST OR PHYSICAL THERAPIST ASSISTANT YOU ARE REPORTING

NAME:

STREET ADDRESS:

CITY, STATE, ZIP:

PHONE:

AUTHORIZATION TO INFORM PHYSICAL THERAPIST OF COMPLAINT

Having been informed of my rights under Data Practices Act,

I, _____, hereby authorize the Minnesota Board of Physical Therapy, its agents, or the agents of the Minnesota Office of Attorney General, to inform _____ of my complaint by providing this physical therapist or physical therapist assistant copies of my complaint documents.

Signature of Complainant

Date

Records Waiver Authorization

TO: ANY PHYSICAL THERAPIST, DOCTOR, HOSPITAL, CLINIC, OR OTHER INSTITUTION:

Having been informed of my rights under Minnesota Government Data Practices Act, I authorize you to furnish a copy of the below-named patient's records in your possession to, or allow those records to be inspected and/or copied by the Minnesota Board of Physical Therapy, its agents, agents of the Attorney General's Office representing the Board, and any other appropriate state or federal governmental agencies.

I further authorize you to testify without limitation as to any and all of your findings and/or treatment referred to in said records.

I release you, the Minnesota Board of Physical Therapy, its agents, and the agents of the Attorney General's Office representing the Board, from liability for so releasing said records or so testifying, and waive any privileges afforded me by the law relating to the disclosure or introduction into evidence of health information.

I also agree to permit, and hereby authorize the Board to use the records of the below-named patient in any legal proceeding which may arise out of this matter.

A photocopy of this form is as valid as the original.

Print or type Patient's Full Name

Patient's Signature (or signature of legal guardian)

Address

Date

Patient's Date of Birth