MBCE Complaint Process & Registration Form

Who We Are & What We Do

The Minnesota Board of Chiropractic Examiners ("MBCE") is a state agency created by the Minnesota Legislature to regulate the practice of chiropractic through licensure, oversight, and enforcement of statutes and rules governing the profession. Our duties include **receiving, investigating, and resolving complaints** against chiropractors.

The Complaint Process

After we receive a complaint, we assign it to a "Complaint Panel." The Complaint Panel (or the Executive Director) determines whether the complaint is "jurisdictional"—meaning that it suggests violations of statutes or rules governing the practice of chiropractic. If a complaint **is not** jurisdictional, we will close the complaint and refer it to another agency, if appropriate. If a complaint **is** jurisdictional, we may request and obtain records, conduct interviews, conference with the chiropractor to discuss the allegations, or take other action as appropriate. Complaints may be resolved in several ways:

- **Dismissal**: A complaint may be dismissed if there is insufficient evidence.
- **Agreement for Corrective Action**: The Complaint Panel and the chiropractor may resolve the complaint by entering a public non-disciplinary agreement by which the chiropractor takes corrective action.
- **Stipulation and Consent Order**: The Complaint Panel and the chiropractor may resolve the complaint by entering into a stipulation (agreement) for disciplinary action. If the full Board approves of the stipulation, it then issues a final public Order imposing disciplinary action.
- **Contested Case Proceedings:** If the complaint cannot be resolved through agreement, the Complaint Panel can initiate a trial-like proceeding before an Administrative Law Judge, which may result in final disciplinary action by the full Board.

Your Complaint: How Your Information Is Used

Complaints and investigative data are classified as confidential or private under the Minnesota Government Data Practices Act. When you submit a complaint to MBCE and/or authorize the disclosure of your health information to MBCE, that information will be used for the purposes of reviewing, investigating, and attempting to resolve the complaint as described above. Your individually identifiable information is generally accessible to MBCE members and staff with work-related needs, the Minnesota Attorney General's Office, other entities authorized by state statute or federal law to access the data (such as the Office of Administrative Hearings, the Office of the Legislative Auditor, or other health licensing boards), and others authorized by court order. Information you provide may be used in legal proceedings. You are not required to provide any information to MBCE—including any individually identifiable information about yourself. Note, however, that failing to provide sufficient information will impede MBCE's ability to investigate or resolve your complaint. Specifically, failing to provide your name and contact information will prevent MBCE from contacting you with additional questions and may limit MBCE's ability to investigate your complaint and pursue action.

Upon receiving your complaint, we will send you a letter acknowledging your complaint. If the matter is resolved through any public action, we will inform you of the resolution. Please note that the complaint-resolution process may take a considerable amount of time, and that we generally cannot share information with you regarding pending complaints.

If you have questions or concerns, please contact the MBCE at chiro.complaint@state.mn.us.

COMPLAINT REGISTRATION FORM

Complainant – Your Name			
Name			
Street Address			
City		**State**	**Zip**
Phone	**Email**		
Check One: I ◯ HAVE / ◯ HAVE NOT authorized the disclosure of my health records by completing the attached form.			

Subject of Complaint – Doctor of Chiropractic, not clinic			
Name			
Street Address			
City		**State**	**Zip**
Phone	**Email**		

Statement of Complaint

Entering your name below acknowledges that you have read, and agree to, the information provided on Page 1 of this Complaint Packet. You further represent that the information contained in your complaint is true and accurate to the best of your knowledge.

Signature of Complainant

Date

AUTHORIZATION TO DISCLOSE HEALTH RECORDS

The purpose of this Authorization is to provide my informed consent to the disclosure of my protected health information (or the information of an individual of whom I am the legal guardian). I am authorizing the party identified below to provide health records to: **Minnesota Board of Chiropractic Examiners, C/O Compliance Specialist, 335 Randolph Avenue, Suite 280, St. Paul, Minnesota 55102**. I understand that I am not required to authorize the disclosure of health records. By completing and signing this form, I am consenting to the following disclosure:

Patient Information (Whose records are being released?)					
First Name		Middle Name		Last Name	
Date of Birth					
Home Address					
City		State		Zip Code	
Phone		Phone (Alt.)		Email:	
Patient ID #					

Provider / Covered Entity (Who will release the records?)					
Provider Name					
Business Name					
Address					
City		State		Zip Code	
Phone		Phone (Alt.)		Email:	

Information to Be Released (Check One)		
FOR DATES / YEARS (specify)		
ALL HEALTH RECORDS	☐	
INCLUDING Chemical Dependency Program Records	☐	You must check this box even if you requested that all health records be released.
INCLUDING Psychotherapy Notes	☐	You must check this box even if you requested that all health records be released.
SPECIFIC RECORDS	(Check below)	

History/Physical	☐	Discharge Summary	☐	Radiology Images	☐	Medications	☐	Laboratory Report	☐
Mental Health	☐	Radiology Report	☐	Surgical Report	☐	Immunizations	☐	Progress Notes	☐
HIV/AIDS Testing	☐	Emergency Room Report	☐	Care Plan	☐	Billing Records	☐	Images/Videos	☐
OTHER:									

By signing this Informed Consent Form, you are requesting that the provider/entity identified above, release health information to the Minnesota Board of Chiropractic Examiners, including the information, records, and data specified by you. You are further acknowledging that: (1) you understand that you may withdraw your consent by informing the provider/entity of your decision in writing, but that this will not revoke consent as to information already shared; and (2) you understand that the provider/entity does not control the use or dissemination of information by MBCE. You further understand that your consent will be effective for **one year from the date of your signature unless specified here as the following date: _____.** You also understand that your health care and payment for health care will not be affected by signing or not signing this form.

_____ _____

Signature Date