COMPLAINT REGISTRATION

MINNESOTA BOARD OF PHYSICAL THERAPY
335 RANDOLPH AVE., SUITE 285
ST. PAUL, 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:

STATEMENT OF COMPLAINT

(Use Additional Sheets as Necessary)

ACKNOWLEDGEMENT & SIGNATURE	
I attest all information provided in this Complaint Registration Form is true and correct to the best of my knowledge.	
SIGNATURE (*electronic signatures are acceptable if completing electronically*):	**DATE:**

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

Mail, Fax or Email these forms to:

Minnesota Board of Physical Therapy
335 Randolph Avenue, Suite 285
St. Paul, MN 55102
Fax: (651) 797-1377
Email: physical.therapy@state.mn.us

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.

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Print or type Patient's Full Name

____

Patient's Signature (or signature of legal guardian)

____

Address

____

Date　　　　　　　　　　　Patient's Date of Birth