MINNESOTA
BOARD OF DIETETICS
AND NUTRITION PRACTICE

335 Randolph Avenue, Suite 210
St. Paul, MN 55102
Phone: 651.201.2764
board.dietetics-nutrition@state.mn.us | mn.gov/boards/dietetics-and-nutrition

COMPLAINT FORM

INFORMATION & INSTRUCTIONS

INSTRUCTIONS

Please provide as much information as possible on pages 2-5 of this form and send them to the Board's office. If you have additional documents, records, or evidence to support your complaint, please include that information for the Board's review.

BOARD AUTHORITY

The Board of Dietetics and Nutrition Practice has jurisdiction over individuals licensed by the Board. These include:

- Dietitians
- Nutritionists

The Board also has the authority to investigate the alleged unlawful practice of the above listed professions.

Please note that the Board is unable to investigate complaints regarding other health professionals who are not licensed by our board, as these professionals are licensed by other health licensing boards. The Board also does not have jurisdiction over hospitals, clinics, or other healthcare facilities. Additionally, we are unable to assist patients with billing disputes.

If the Board is not the appropriate agency for your complaint, you may find contact information for other agencies and health licensing boards in our FAQs.

NOTICE OF RIGHTS UNDER THE MINNESOTA GOVERNMENT DATA PRACTICES 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 this 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.

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YOUR CONTACT INFORMATION

FIRST NAME:	LAST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBER(S):	EMAIL ADDRESS:	

Who is submitting this complaint? *Check all that apply*:

- ☐ A patient
- ☐ A Board of Dietetics and Nutrition Practice licensee
- ☐ A friend or family member of a patient
- ☐ An agency
- ☐ A licensee of another board:
- ☐ Other: _____

PROVIDER'S INFORMATION

Please list the provider(s) you are complaining about. You can find information on any provider licensed by our board by visiting our website and using the "Verify a License" tab.

FIRST NAME:	LAST NAME:	
LICENSE TYPE: ☐ Dietitian ☐ Nutritionist ☐ Unlicensed Practice ☐ Unknown		LICENSE NUMBER, if known: PHONE NUMBER:
NAME OF EMPLOYER/HOSPITAL/CLINIC:		
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:

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STATEMENT OF COMPLAINT

Patient Name:	Patient Date of Birth:	Relationship to Patient:

Name & Address of Hospital or Clinic where Conduct/Care Occurred:

Dates when Conduct/Care Occurred:

Describe What Happened (You may attach additional pages if you like)

ACKNOWLEDGMENT & SIGNATURE

I attest all information provided in this Complaint Form is true and correct to the best of my knowledge.

Signature:	**Date:**

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STATEMENT OF COMPLAINT (cont.)

ACKNOWLEDGMENT & SIGNATURE

I attest all information provided in this Complaint Form is true and correct to the best of my knowledge.

Signature:	**Date:**

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MEDICAL INFORMATION RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH DATA

To: Any Privacy Officer/Health Care Professional

Having been informed of my rights under the Minnesota Government Data Practices Act, I authorize you to furnish a copy of my records in your possession to, or allow those records to be inspected and/or copied by the MN Board of Dietetics and Nutrition Practice, its agents, agents of the Attorney General's Office representing the Board, and any other appropriate state or federal governmental agencies as allowed by law.

I further authorize you, as a health care professional, to testify without limitation as to any and all of your findings and/or treatment referred to in said records and authorize the Board to use the information you provide along with the records in any legal proceeding which may arise out of this matter.

I release you, the MN Board of Dietetics and Nutrition Practice, 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 disclosure or introduction into evidence of this health information.

I understand subsequent release of this information may result in the information no longer being protected by the HIPAA Privacy Rule (45 Code of Federal Rules 164).

A photocopy of this form is as valid as the original. This authorization expires at the end of one year from the date of consent, unless expressly revoked in writing earlier. Revocation does not limit the Board's use of the information obtained prior to the date of revocation.

Print or Type Patient's Full Name:	**Patient's Date of Birth:**
Address of Patient or Patient's Legal Representative:	
Signature of Patient or Patient's Legal Representative:	**Today's Date:**