



**State of Tennessee
Office of Investigations**

Tennessee Department of Health
Office of Investigations
Heritage Place, Metro Center
227 French Landing, Suite 201
Nashville, TN 37243

Phone (615) 741-8485
TN Toll Free 1-800-852-2187

ALLEGATIONS REPORT

COMPLAINANT	NAME (FIRST, MIDDLE, LAST)		HOME PHONE ()
	BUSINESS NAME (IF APPLICABLE)		WORK PHONE ()
	STREET ADDRESS		CELL PHONE ()
	CITY/COUNTY	STATE	ZIP
NAME OF PATIENT (if other than yourself)	NAME (FIRST, MIDDLE, LAST)		HOME PHONE ()
	BUSINESS NAME (IF APPLICABLE)		WORK PHONE ()
	STREET ADDRESS		CELL PHONE ()
	CITY/COUNTY	STATE	ZIP
RELATIONSHIP TO PATIENT	<input type="checkbox"/> PATIENT <input type="checkbox"/> FAMILY MEMBER Specify: _____ <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> FRIEND		
	<input type="checkbox"/> EMPLOYER (attach copies of internal investigation and drug screens) <input type="checkbox"/> OTHER Specify: _____		

SUBJECT OF REPORT (PRACTITIONER)	NAME (FIRST, MIDDLE, LAST)		PROFESSION: (Dr., Dentist, RN, etc.)
	BUSINESS NAME (IF APPLICABLE)		LICENSE NUMBER, IF KNOWN
	STREET ADDRESS		WORK PHONE ()
	CITY/COUNTY	STATE	ZIP



State of Tennessee Office of Investigations

Authorization for Release of Patient Information

TO: Any and all treating physicians and facilities

I, the undersigned, hereby authorize any and all licensed health care practitioners (including but not limited to physicians, psychiatrists, psychologists, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, emergency medical attendants) and others who have participated in providing any care or service to me to discuss any communication, whether confidential or privileged, and to provide **full** and **complete** patient reports and records, including but not limited to patient histories, x-rays, examination and test results, reports, or records to the **Tennessee Department of Health, Office of Investigations** (or any official representative of that Office) for investigation, reproduction, or other use.

I, the undersigned, am also fully aware that the communications and records of such communications, between myself and a health care practitioner may be by law "privileged" and that as such they can only be disclosed or released with my knowing and voluntary consent to waive the privilege I hold as to those communications and/or records. I hereby knowingly and voluntarily waive the privilege I hold as to any and all communications and records those providers have regarding the care and services I have received from them or members of their staff.

Date

Patient Signature

Date of Birth

Social Security Number

If patient is a minor or otherwise lacks capacity to sign:

Authorized Person Other Than Patient

Relationship

{Note: If acting in capacity of legal guardian, attach copy of Power of Attorney, or other legal document.]

If you are the patient/legal guardian, this form must be completed in its entirety, in order for your complaint to be processed.