

Wyoming Board of Medicine

Serving the public and practitioners since 1905

320 W. 25th Street, Suite 200 • Cheyenne, WY 82002

Phone: 307-778-7053 • Fax: 307-778-2069 • Toll Free within state: 800-438-5784

Email: wyomedboard@state.wy.us • Website: <http://wyomedboard.state.wy.us>



Matthew H. Mead
Governor

Board of Medicine use only
Complaint No: _____

COMPLAINT AGAINST A WYOMING PHYSICIAN and/or PHYSICIAN ASSISTANT

Please print or type all information

Your Name: _____ Date: _____

1. Your Address:

Street City/State Zip Code
Daytime Phone: _____ Evening Phone: _____

2. Your relationship to patient involved: (circle one)

Self Spouse Parent Child Sibling
Colleague Friend Guardian None Other: _____

3. Name of Patient: _____ Date of Birth: _____

4. Patient's Mailing Address and Telephone Number:

Street or P.O. Box City/State Zip Code
Daytime Phone: _____ Evening Phone: _____

5. Full name of physician and/or physician assistant about whom you are complaining:

6. Name and facility and address where treatment was delivered:

Name Address City/State Zip Code

7. Dates of Treatment: From: _____ To: _____

8. If treatment involved a hospital, please provide the name and location of the hospital:

Name Address City/State Zip Code

9. Date/s of hospitalization: From: _____ To: _____

10. Name of any other practitioner/s involved in this patient's treatment:

11. Address of any other practitioner/s involved with this patient's treatment:

Name Address City/State Zip Code

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize
Please print name

Name of Practitioner (Physician(s) and/or PA(s) about whom complaint is being made)

Name of Hospital or Treatment Facility (if applicable)

Name(s) of other treating Practitioner(s), Hospital(s) and/or Treatment Facility(ies) (if applicable)

TO RELEASE THE MEDICAL RECORDS AND ENTER INTO DISCUSSION ABOUT:

Patient's Name

Covering period from _____ to _____

Relating to the patient's examination, diagnosis, treatment, billing and prognosis to the:

Wyoming Board of Medicine
320 West 25th St., Suite 200
Cheyenne, WY 82002

This authorization shall be considered valid from the date below until such time as the Board receives written notice that it has been revoked. Authorization for Release of Medical Records cannot be revoked if action has already been taken based on the authorization or if access to the records is otherwise authorized by law.

Patient's Signature Date

OR

Signature of authorized representative, parent or guardian (indicate legal relationship to Patient) Date

IMPORTANT: SIGNATURE MUST BE NOTARIZED!

County of _____)

State of _____) ss.

Subscribed and sworn to before me this _____ day of _____, _____.

SEAL

Notary Public

My commission expires: _____