



Santa Cruz County Medical Society

SCCMS Patient/Physician Mediation Service

The Santa Cruz County Medical Society (SCCMS) is a non-profit, professional association of physicians dedicated to maintaining quality medical care and improving patient relations. SCCMS has a variety of peer review committee members who volunteer their time towards these goals.

If you have a complaint about a physician's medical and/or billing practices, we encourage you to personally discuss the issue with your physician. The medical society's Mediation Committee has often found that open communication between you and your physician, or his/her office staff, often results in the resolution of most problems.

If the treating physician is **not** an SCCMS member, we are **unable** to provide mediation services. Contact the medical society to determine whether or not your physician is a member.

The medical society's ability to be of service will depend upon the willingness of the physician and the patient to participate in our mediation process. All recommendations by the Mediation Committee are advisory only. While the SCCMS will attempt to mediate this dispute, it has no authority to take action against a physician's license. The Medical Board of California is the **only** authority in the state that may take disciplinary action against the license of a physician.

One of the goals of the SCCMS Mediation Committee is to resolve conflicts **before** they escalate into litigation. Therefore, the committee cannot review your complaint if a lawsuit has been undertaken, if your complaint was filed with

the Medical Board of California, or if a disputed fee is in the hands of a collection agency.

All peer review committee proceedings, including those of the Mediation Committee, are confidential and will not be discussed outside of the normal committee proceedings.

Quality of care complaints against physicians who are **not** members of Santa Cruz County Medical Society will be referred to the Medical Board of California. The toll-free number of the Medical Board is 1-800-633-2322. For information on the Consumer Complaint form with instructions, go to http://www.medbd.ca.gov/consumer/complaint_info.html

Correspondence can be sent to:

Medical Board of California
2005 Evergreen Street #1200
Sacramento CA 95815

Please complete the attached SCCMS Patient Grievance Reporting Form and send it to:

Santa Cruz County Medical Society
Attention: Mediation Committee
1975 Soquel Drive #215
Santa Cruz CA 95065-1821

Note: The SCCMS Mediation Committee meets on an as-needed basis. Processing of complaints may take several weeks.

Updated 4/27/09

SCCMS Patient Mediation Report Form

Mail to: 1975 Soquel Drive, Suite 215, Santa Cruz, CA 95065-1821

Please print or type.

Date: _____

Name of Patient: _____

Your Name: _____

Relationship to patient: _____

Mailing Address: _____

Telephone: _____

Name of Physician: _____

Medical Specialty: _____

Have you discussed your problem with the physician and/or office staff named in this complaint? YES NO

Do you have any objection to being contacted by a committee member? YES NO

May we contact the physician involved? YES NO

May we contact your primary care physician, if different from above? YES NO

TYPE OR PRINT YOUR COMPLAINT IN THE FOLLOWING SPACE. If necessary, attach an additional page. Attach copies of any pertinent documentation that may assist in the review of your complaint.

Updated 4/27/09

Authorization for Disclosure and Use of Protected Health Information by the Santa Cruz County Medical Society

As required by California law and the Health Information Portability and Accountability Act of 1996 (HIPAA), your physician may not use or disclose your individually identifiable health information without your authorization except as provided by California law and, if applicable, in the physician practice's Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby authorize the medical practice identified on the accompanying complaint to use and disclose health information concerning

(patient's name and address) as follows:

Health information to be used or disclosed (check only one box):

Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

All psychotherapy notes may be released, except as specifically provided below:

This health information may be disclosed to the Santa Cruz County Medical Society. The information will be used only to investigate and attempt to resolve the accompanying complaint.

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization. I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now and will remain in effect until the Medical Society has finished handling this grievance.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient (to the extent minor could not have consented to the care)
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient.

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