National Alliance of Methadone Advocates

CONFIDENTIAL

Grievance/Compliment Report

All information that is provided will be held strictly confidential in the same manner as the patient protections described in the U.S. Federal Confidentiality Regulations 42 CFR and the Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) as established by the Department of Health and Human Services (HHS) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to assist you at the maximum level of follow-up and outcome, we do request certain personal information below. However, if you do not want us to disclose your name for any reason, we will honor your wishes.

Information on Person Filing Report *Date Filed:*

Name: _____

Address: _____

City: _____ ***State/Providence:*** ____ ***Zip/Postal Code:*** _____ ***Country:*** _____

Phone: _____ ***Fax:*** _____

Other Phone: _____ ***Email:*** _____

If we contact the clinic or agency do you want to be informed of the results? (If by mail please include a self-addressed envelope.) ***Yes*** _____ ***No*** _____

Information About Agency Under Report

Name of Clinic/Agency: _____

Address: _____

City: _____ ***State/Providence:*** _____ ***Zip/Postal Code:*** _____ ***Country:*** _____

Phone: _____ ***Fax:*** _____

Name/Title of Person to Contact: _____

Type of Program/Agency, Check Only One:

☐ **Program** ☐ **Supportive Services (i.e. vocational homeless shelter)**

☐ **State Agency** ☐ **Other** _____

(i.e. local law enforcement, probation/parole officer, hospital).

Information About Incident

Category of Incident Choose One Below: ***Date of Incident:*** _____

☐ **Threat of Termination/Discharge** ☐ **Dosage Policies**

☐ **Urine Testing Procedures** ☐ **Punitive Staff**

☐ **Medication Hours or Schedule** ☐ **Pick-up Schedule Problems**

☐ **Unfair or Exorbitant Cost of Treatment** ☐ **Other, describe:** _____

Please Describe Incident in a Concise Way.

By filing an Grievance/Compliment Report you are helping NAMA keep track of programs and how they are operating. If you need help you should contact NAMA immediately at (212) 595-6262. NAMA does investigate all Grievance/Compliment Reports and discusses patterns of Grievances with regulatory agencies and professional organizations.

Policies that are beneficial or incidents that were managed well by a program may also be reported. These reports will be used to demonstrate alternative policies that can be used by programs and to commend the program that has developed and used them.

Please complete and mail to:

Claude Hopkins, Grievance Coordinator
Email: ch.grievance@methadone.org
National Alliance of Methadone Advocates
435 Second Avenue
New York, NY 10010
Phone/Fax: (212) 595-nama

Together, we can make a difference.

NAMA Information

Investigator: _____
Print Name

Date Received:

Date Completed: ***Report Yes ___ No ___*** ***Initial Upon Completion*** _____

Comments:

AUTHORIZING Patient's NAME (please print): Last: _____ First _____ M.I.____

Date of Birth: _____ Social Security #: _____ - _____ - _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND DISCUSSION BETWEEN

National Alliance of Methadone Advocates (NAMA)

435 Second Avenue
New York, NY 10010
tel/fax: 212 595-6262

AND

_____ (Person/Facility)

_____ (Address)

_____ (Address)

_____ (City, ST, Zip)

(telephone) _____ (fax)_____

WE REQUEST ALL PERTINENT MEDICAL RECORDS FROM ATTENDING PHYSICIANS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS. THE PURPOSE OF THIS RELEASE IS TO ALLOW WRITTEN AND/OR VERBAL COMMUNICATION PERTAINING TO MEDICAL INFORMATION INCLUDING BUT, NOT LIMITED TO: clinical and discharge summaries, other complaints, counselors notes, medical orders, the results of medical and psychiatric evaluations, case reports and psychological assessments. THIS RELEASE ALSO AUTHORIZES COMMUNICATIONS in verbal or written form between NAMA and its representatives _____ and the above named person facility or facility representatives pursuant to the patient listed above. This authorization may be withdrawn in writing at any time and terminates on _____.**

ADDITIONAL INFORMATION REQUIRED: _____

_____

_____

I understand that information specific to my medical history can be released with this consent. I can cancel this consent at any time but I understand the cancellation will not affect any information previously released under the agreement. I further understand that my notice of cancellation must be in writing.

I understand that information about my case is confidential and protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR, Part 2 and 45 CFR, Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I approve the release of this information. I understand what this agreement means and I am satisfied with my explanations which I may have requested and received.

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed name	Printed name
_____	_____
Date of Signature	Date of Signature

** *According to HIPPA the new patient privacy regulations a release must have a specific start time and end time which should not be more than one (1) year for compliancy.*

Form: 105E-R022004