



**Please TYPE or PRINT legibly. Complete sections 1 — 5. Attach additional pages if necessary. Attach copies of supporting documentation or other relevant papers. If you need assistance in completing this form, please contact the Office of the Ombudsman and we will assist you.**

<b>1</b>	Name: _____ Mailing Address: _____ _____ Daytime Phone (_____) _____ May we contact you at this number? Yes No How else may we contact you? _____ Email Address: _____
<b>2</b>	Name of clinic/program: _____ City: _____ Have you gone through other channels about your complaint? Yes No If yes, please describe your prior attempts to resolve the matter and attach copies of all related paperwork. _____ _____ _____ _____ _____ Name(s) and phone number of the person(s) you contacted regarding the complaint: _____ _____ _____
<b>3</b>	Have you asked anyone else for assistance? Yes No If yes, may we talk to that person about your complaint? Yes No Names and phone numbers: _____ _____ _____
<b>4</b>	Please give us any other information we need to help us research your complaint: _____ _____ _____

Use these lines to describe your complaint.

5 What occurred? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did it happen? \_\_\_\_\_  
\_\_\_\_\_

Who was involved? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where did it take place? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you like to see this problem resolved? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WAIVERS**

I understand that only authorized personnel of the Office of Ombudsman will have access to my file and that no records, statements or data contained therein may be used to prosecute, charge or otherwise infringe upon my rights. Thus, the confidentiality of my records is assured to me as stipulated by all confidentiality laws including 42 CFR, Part 2 and Article 7 (commencing with Section 5325) of subchapter 2, part 1 of Division 5 of the Welfare and Institution Code of California pertaining to Drug and Alcohol Abuse Patient Records, as well as the health insurance portability and accountability act ( HIPAA ). Furthermore, I am aware that my written authorization is needed before any confidential information is released, except under legally mandated conditions, including but not limited to the following:

1. When child abuse is observed or suspected (*W&I Code section 11165*)

2. When elder/dependent adult abuse is observed or suspected (*W&I Code section 11630*)
3. To prevent bodily harm to another person (*Tarasoff vs. Regents of University of California, 1976*)
4. To prevent self-induced harm or death (*Johnson vs. County of Los Angeles, 1983*)

In order to facilitate the services of the Office of Ombudsman in handling the foregoing complaint or concern, I **hereby authorize** the Office of Ombudsman to contact any witnesses, patient records, or otherwise obtain information required in the performance of the duties of the Ombudsman, with the understanding that such inquiries will be conducted discreetly.

I agree that any communication with the Office of the Ombudsman, whether written or oral, cannot be subpoenaed or otherwise discovered for any purpose, legal or otherwise. I will not, at any time, attempt to compel Ombudsman to testify on my behalf or for any other reason, nor will I, at any time; attempt to compel disclosure of records, files, documents or any information in the control of the Ombudsman.

I acknowledge that the Ombudsman shall not be liable for any indirect, special or consequential damages, or any damages arising out of or in connection with the use or performance of this information, advice, or service. I agree that use of the services of the Ombudsman is entirely at my own risk, and that the Ombudsman services are provided without warranty of any kind, either express or implied, including without limitation any warranty for information, services, counseling, uninterrupted access, or products and services provided.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Thank you for taking the time to complete this form. The information received will be utilized to improve your experience and relationship with the Aegis family of corporations.**

**Please mail this form and all related papers to:**

**Office of the Ombudsman  
P.O. Box 6162  
Ventura, CA 93006**

**For Ombudsman Use Only**

**Date Received:** \_\_\_\_\_ **Date completed:** \_\_\_\_\_

**Resolution: Yes No (Attach report)**

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Attach additional pages, as needed.**

