Riverside County Mental Health Plan
Quality Improvement Coordinator
P.O. Box 7549
Riverside, CA 92513
1-800-660-3570

For Office Use Only
By: ______________________________
Forward to: ______________________
Date: ____________________________
Date Client Notified: _____________
Outcome: _________________________

GRIEVANCE REQUEST

This form is used to file a grievance. If you need assistance in completing this form, you can request help from your provider, or calling the Quality Improvement Program at (800) 660-3570 or Patients' Rights at (800) 350-0519, or locally, (909) 358-4600. A signed Release of Information Form needs to be submitted with this grievance request. This grievance can be submitted to your clinician, the Program Supervisor, or mailed directly to the Quality Improvement Program at the address shown above.

PLEASE PRINT

Your address and phone number are important. We need this information to contact you about the grievance outcome.

Your Name: ____

Your Address: ____

Your Daytime Phone: ____

Check here if you are currently a resident of a Medi-Cal funded residential treatment program.

Current Provider: ____

If Applicable, Person Representing You: ___________________________________

Their Address: ____

Their Daytime Phone: ____

What is the problem?____

What would you like the solution to be?

Whom have you talked to about the problem?

Client (or Client's Representative) Signature **Date**

You will not be subject to discrimination or any other penalty for filing a grievance. Your confidentiality will be protected at all times in accordance with State and Federal law.

Riverside County Mental Health Plan
Authorization for Release of Information From the Medical Record

____

Client's Last Name First Name Middle Name Date of Birth

____

Street Address City Zip Code Telephone Number

===

I, the undersigned, herby authorize: (Name and address of health care service provider with records)

____

Health Care Provider Name

____

Street Address

____

City State Zip Code

And to: **Riverside County Mental Health Plan**
Quality Improvement (QI)
P.O. Box 7549
Riverside, CA 92513

access to my medical records for the purpose of ______________________________.
I further authorize you to provide such copies thereof as may be requested.

The authorization is subject to the following limitations:

_____ 1. Confined to records regarding treatment for the period from ____________
______________________________ to________________________________.

_____ 2. Confined to records regarding admission and treatment for the following medical condition or injury: ____
____

_____ 3. Confined to the following specified information: ____________________
____

_____ 4. All medical records.

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate three (3) months from the date of consent without express revocation.

____
Signature of Client, Legal Guardian, Representative (Please Circle)

____
Date

____
Signature of Witness

____
Date

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure.