Personal Health Information Act
Complaint Form

This form is provided to you to allow you to provide all information related to your complaint. You may also send a letter outlining your complaint to the Personal Health Information Act Contact:

Jan Merrill
jan@alliancedental.ca

1. PATIENT/CLIENT/RESIDENT NAME AND CONTACT INFORMATION (please print clearly)

Last Name First Name Middle Initial

_____

Mailing Address

_____

Day time phone number

_____

E-Mail address (only required if you wish to be contacted by e-mail)

How do you wish to be contacted? Please circle: Phone, Regular Mail, Email

If you are making the complaint on behalf of someone else, please provide your name and contact information:

_____

Last Name First Name Middle initial

Relationship to patient/client/resident_____
Mailing address_____
Daytime telephone number_____

E-mail address (only required if you wish to be contacted that way)

_____

How do you wish to be contacted? Please check one □ Phone □ Regular mail □ E-mail

You must attach a copy of the document authorizing you to make the complaint.
Example: written consent of the individual, guardianship documents.

2. **DETAILS OF THE COMPLAINT**

Please provide as much information as you can about the complaint you are making. Please include details of the incident(s) leading to your complaint, the name of any individuals who are involved in the incident(s), the date when it occurred and any information about your efforts to attempt to resolve this complaint outside of the complaint process (i.e. informal discussions with someone involved in the incident.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please attach any documents relevant to the complaint

3**. RESOLVING THE COMPLAINT**

What do you think should happen to resolve your complaint?

_____
_____
_____
_____
_____
_____
_____
_____
_____

4. CONSENT AND SIGNATURE

In order to fully investigate your complaint, we will need to review your personal health information relevant to your complaint. Please check and initial your response.

___ □ I consent to Jan Merrill reviewing my personal health information in order to fully

investigate my complaint.

___ ☐ I do not consent to Jan Merrill reviewing my personal health information in order to fully investigate my complaint.

We may also need to discuss the facts presented on this form and any other information related to the complaint with individuals in our organization. We would only disclose information relevant to the complaint.

___ ☐ I consent to Jan Merrill discussing the facts presented on this form and any other information related to the complaint with individuals at Millcove Dental]. I understand that Jan Merrill will only disclose information relevant to my complaint.

Please note that we may not be able to fully investigate your complaint if we do not have access to all the relevant information related to your complaint

_____

Signature Date:

Please deliver or mail your original form to:

Jan Merrill

Phone: 902-454-6143

Armview Dentistry

2625 Joseph Howe Drive #34
Halifax, Nova Scotia
B3L 4G4