



**Iowa Board of Nursing  
Enforcement Unit**

Iowa Board of Nursing  
400 SW 8<sup>th</sup> Street, Suite B  
Des Moines, IA 50309-4685

Phone 515-281-6472  
Fax 515-281-4825  
Website nursing.iowa.gov

**COMPLAINT FORM**

*Please print or type*

**NURSE BEING REPORTED**

Name (Last, First, Middle):

License Number:

Home Address (Number & Street):

City:

State:

Zip:

Employer:

Business Address (Number & Street):

City:

State:

Zip:

Home Phone:

Cell Phone:

Business Phone:

Additional Information (Birthdate, Former Name, E-mail Address, etc.):

**PERSON REGISTERING COMPLAINT**

Name (Last, First, Middle):

Address (Number & Street):

City:

State:

Zip:

Home Phone:

Cell Phone:

Business Phone:

Relationship to Nurse: (Please circle)

**Employer**

**Patient**

**Coworker**

**Friend**

**Other: Explain \_\_\_\_\_**

\*If you are the patient, please complete the attached Release Form

**Go to next page for the details of the complaint.**

**DETAILS OF COMPLAINT:** Please write legibly. Use a separate report form for each individual. Provide pertinent information such as: the chronological order of events, names of witnesses and telephone numbers, copies of documents relevant to the situation being reported.

I certify that all the information that I have provided herein is true and correct to the best of my knowledge.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

**PLEASE RETURN TO:** Iowa Board of Nursing  
RiverPoint Business Park  
400 SW 8<sup>th</sup> Street, Suite B  
Des Moines, IA 50309-4685  
Phone: 515-281-6472  
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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

I, the undersigned do authorize and request \_\_\_\_\_  
(Name of Health Care Provider)

To release to the Iowa Board of Nursing, 400 SW 8<sup>th</sup> Street, Suite B, Des Moines, IA 50309-4685.

This information is being disclosed and may be used only for the purpose of CONFIDENTIAL INVESTIGATION.

I agree that \_\_\_\_\_ may release the following information from these medical records:  
(Name of Health Care Provider)

- History & Physical
- Discharge Summary
- Social History
- Consultation
- Lab, X-ray, EKG
- Treatment Status
- Other (please specify) \_\_\_\_\_
- As much information as \_\_\_\_\_, in its full discretion.  
(Name of Health Care Provider)

deems reasonably necessary for the purposes set forth by me for release.

This authorization is effective for \_\_\_\_\_ from the date on which it is signed.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to The Iowa Board of Nursing and the above named Health Care Provider.

I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by

\_\_\_\_\_  
(Name of Health Care Provider)

<p style="text-align: center;"><b>PROHIBITION ON REDISCLOSURE</b></p> <p>This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal Law for Alcohol/Drug Abuse Records or by State Law for Mental Health Records, Federal Requirements (42 C.F.R. Part 2) and State Requirements (Iowa Code ch.228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or Criminal penalties may attach for unauthorized disclosure of Alcohol/Drug Abuse or Mental Health Information.</p>	<p>I acknowledge that the information to be released may include material that is protected by the state and/or federal law applicable to either mental health and/or drug/alcohol abuse or both. My signature authorizes release of all such information as specified above.</p> <p>_____</p> <p style="text-align: center;">(Signature of Patient or Patients Authorized Representative)</p> <p>_____</p> <p style="text-align: center;">(Relationship of Authorized Representative)</p>
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