

# Health and Disability Commissioner Complaint Form



This form is designed to help you make a complaint to the Health and Disability Commissioner about the provision of health or disability services to you or someone else. Before filling in the form, you may wish to consider talking to the provider you are unhappy with. If you would like assistance with this, you can seek the assistance of an Advocate to help you resolve your complaint directly with the provider, instead of going to the Commissioner. You can contact a Health & Disability Advocate on Free Phone: 0800 555 050.

## Part A – About You

### Your details (The complainant)

Name: Ms/Mrs/Miss/Mr/Dr .....

Address: ..... Postal Code.....

Home Phone: ..... Business Phone:.....

Mobile..... Email:.....

NHI number.....

Preferred means of contact: (tick) Email  Post  Phone

If there is more than one complainant, please include the details on an extra page.

### Fill out this box only if you are complaining on behalf of someone else

Name of that person: Ms/Mrs/Miss/Mr/Dr .....

Address: .....

Home Phone: ..... Business Phone:.....

Mobile..... Email:.....

NHI number.....

**The Privacy Act and Health Information Privacy Code state that we may only release personal information (including personal health information) to people who are entitled to that information. Therefore, if you are not the consumer of the services being complained about, please advise whether you are: (tick one of the following options)**

Parent where the consumer is under 16

Enduring Power of Attorney (EPOA) where the consumer has been certified as not competent and the EPOA activated

Welfare/legal guardian

Executor of the consumer's estate where the consumer is deceased

Other  Please specify your relationship to the Consumer.....

If you have ticked 'Other', is the Consumer aware you are making a complaint on their behalf? (circle) Yes / No

If no, is there a particular reason they are not aware of this complaint?.....

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**If the Consumer is aware, please ask them to confirm, in writing or by email, that they support the complaint and whether they agree to the release of their personal information (including personal health information) to you.**

**Fill out this box if someone is representing you (eg, an advocate, friend, relative, lawyer)**

Name of representative: .....

Organisation: .....

Postal Address: .....

Home Phone: ..... Business Phone:.....

Mobile.....Email:.....

## Part B – Your Complaint

The Commissioner deals with complaints about the provision of health and disability services. This includes public and private services, hospitals and individuals (such as general practitioners, dentists, naturopaths, rehabilitation workers, and caregivers). On receipt of your complaint, the Commissioner decides how it will be handled. To assist, please give us all the information relevant to the issue/s you are complaining about. A Complaints Assessor is available on 0800 11 22 33 to help you decide what may be relevant to your complaint.

### I am complaining about:

Name of the service provider (person/organisation):.....

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Type of health or disability service provider (eg, doctor): .....

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Organisation (if not already listed).....

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Address: .....

Phone Number (if known).....

**Please note that a copy of your complaint may be sent to the service provider you are complaining about as well as any other provider who may be able to assist in our assessment of your complaint. If you have any concerns about our doing this, please contact this Office as soon as possible.**

What is your or the Consumer's relationship to this person/organisation (eg, patient, service user, professional colleague, employer, employee)?

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### I am also complaining about:

Name of the service provider (person/organisation):.....

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Type of health or disability service provider (eg, doctor): .....

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Organisation (if not already listed).....

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Address: .....

Phone Number (if known).....

What is your relationship to this person/organisation (eg, patient, service user, professional colleague, employer, employee)?

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I have also sent this complaint to: .....

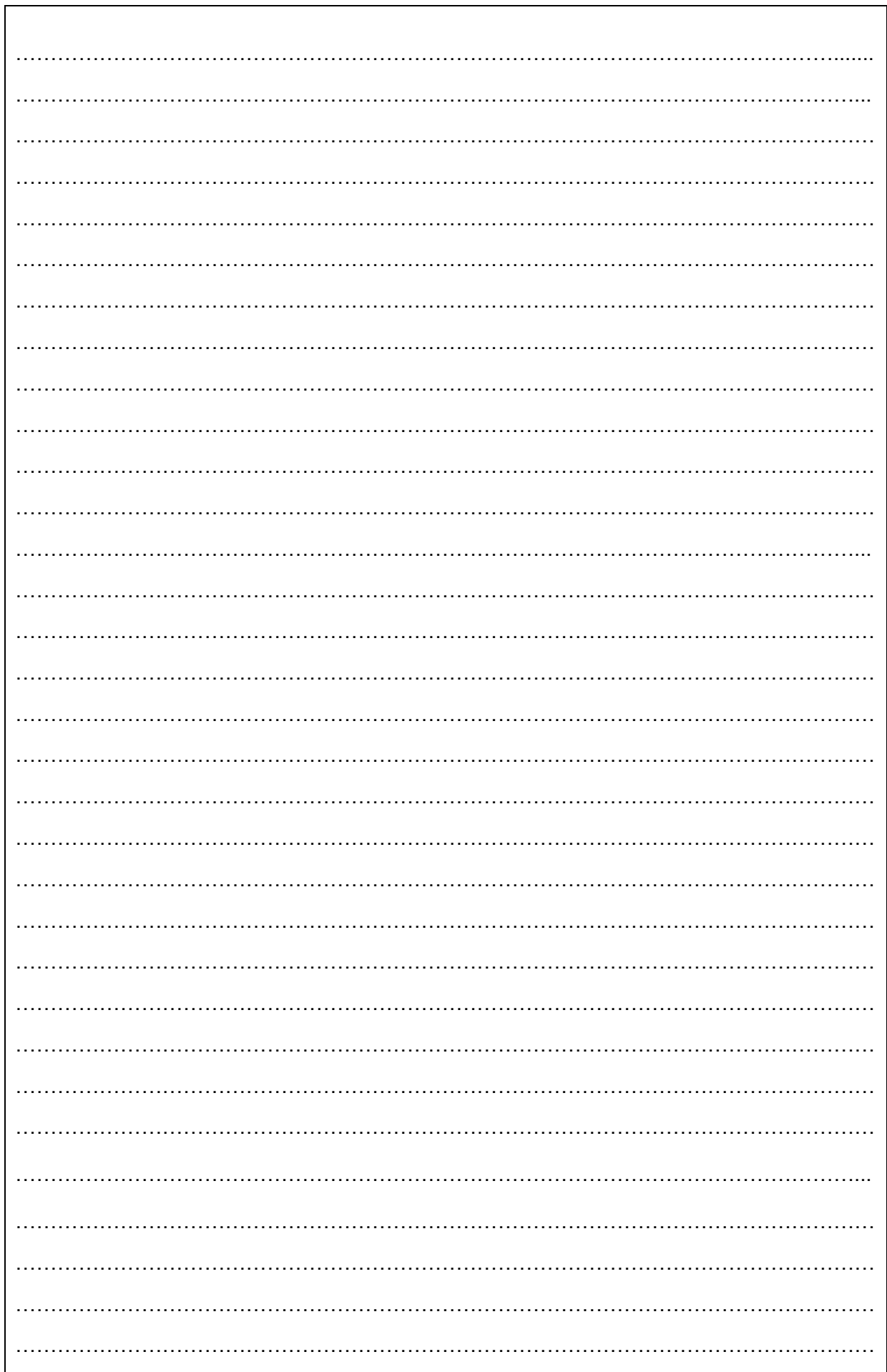
(eg provider, advocate)

If you are complaining about more than two people or organisations please give us the same information on an extra page. If you do not know the name of the person, please describe as best as you can the person's position or the job he or she performed, and the time of the incident (eg, evening/morning shift).

Are you receiving ongoing services from the provider(s) you are complaining about?

(circle) Yes /No





If you have more information, please add extra pages.

## Part D – Further Information

### Witnesses

Are there other people who can help us with any enquiries we may make? Please tell us their names, how to contact them, and explain how they may be able to help us.

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### Documents

Please give us copies of any documents that may help us to consider your complaint (for example, clinical records, medical reports, and any records of conversations).

### Results

What do you want to achieve by making this complaint? .....

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### Other ways of resolving your complaint

Have you tried to resolve your complaint in any other way (for example, writing to or meeting with the health or disability service providers, working with an advocate)? If so, please give details, including the outcome and copies of any correspondence with the provider, or notes from meetings that you attended:

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## Part D – Further Information *continued*

### Complaints to other agencies

Have you made a complaint to another agency about this matter (for example, the Police, the Human Rights Commission, the Privacy Commissioner, ACC)?  
(circle) **Yes** / **No**

If yes, please give details, including the outcome.

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### Complaints to other parties

Have you sent a copy of this complaint to any parties (for example, the Provider, Advocacy, ACC)? (circle) **Yes** / **No**

If yes, please give details.

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### Remember:

- to attach any copies of documents, medical records, or reports; and
- if you need help to fill in this form, please contact one of our Complaints Assessment staff on 0800 11 22 33 or a Health & Disability Advocate on Free Phone: 0800 555 050.

### This form should be sent to:

Health and Disability Commissioner  
P O Box 1791  
Auckland

Phone: 09 373 1060  
Freephone: 0800 11 22 33  
Fax: 09 373 1061

This form can also be completed electronically through the Commissioner's website at [www.hdc.org.nz](http://www.hdc.org.nz).