



MINNESOTA BOARD OF DENTISTRY

University Park Plaza, 2829 University Avenue SE, Suite 450
Minneapolis, MN 55414-3249 www.dentalboard.state.mn.us
Phone 612.617.2250 Toll Free 888.240.4762 Fax 612.617.2260
MN Relay Service for Hearing Impaired 800.627.3529

Dear Complainant:

The purpose of this letter is to assist you in understanding the process for filing a complaint against a Minnesota dentist, dental hygienist, or licensed dental assistant. These dental care providers are regulated by the Minnesota Board of Dentistry. Below are the forms you may use to file your complaint. The information you provide will be evaluated to determine whether the matter is one which justifies Board action against the provider.

PROVIDE YOUR IDENTITY INFORMATION: The Minnesota Board of Dentistry does not accept anonymous complaints. When completing the forms, you need to provide your identity information. You have a choice about whether to allow us to release a copy of your actual complaint to the dental provider (see description below relating to the enclosed form titled, "AUTHORIZATION TO RELEASE COMPLAINT").

Your identity will be kept confidential under Minnesota Statute §13.41, subd. 2. Once a complaint matter is resolved (through closure, taking corrective action or taking disciplinary action), the classification of the complaint and investigation information changes from "confidential" to "private." You may call to speak with a Board Complaint Unit staff member if you would like to learn more about the classification of data maintained by the Board.

There are rare instances when the Board's proposed resolution for a complaint matter is contested by the dental provider and your identity could be disclosed.

Please also be aware that failing to provide the Board with identity information may result in the Board not being able to adequately investigate alleged violations. It also prohibits Board staff from providing you with updates regarding the Board's review and resolution of your complaint.

FORMS: Before completing these forms, please understand that **the Board of Dentistry does not assist individuals in obtaining monetary refunds** related to dental treatment. The Board of Dentistry's authority is limited to taking disciplinary or corrective action against a dental care provider when warranted in order to protect the public at large. If you are seeking monetary reimbursement, please call the Board office at (612) 548-2124 for information about where you may seek such assistance.

1. COMPLAINT REGISTRATION FORM: While we do not wish to complicate the filing of complaints, we ask that you submit your complaint in writing so that it can be properly evaluated. Please provide as much detail as you can regarding all facts which relate to the complaint, including records which you may have or know about, and any attempts you may have already made to resolve your complaint with the provider. If you are unable to submit your complaint in writing, please call our office.

(continued, FORMS)

2. AUTHORIZATION TO OBTAIN RECORDS: If your complaint alleges that the dental care provider improperly treated you in some way, it will probably be necessary for the Board to obtain your dental records so that your complaint can be properly evaluated. For this reason, we have included an AUTHORIZATION TO OBTAIN RECORDS form for your signature. It is not legally necessary for you to sign this form; your complaint will be evaluated regardless of whether you sign. However, it may be easier for the Board to evaluate and resolve your complaint if you sign this authorization.

3. AUTHORIZATION TO RELEASE COMPLAINT: When we analyze your complaint, we will likely seek a response from the provider. When requesting the provider's response, it could be helpful to share your complaint with the provider. For this reason, we have enclosed an AUTHORIZATION TO RELEASE COMPLAINT form for your signature. This form would authorize us to mail a copy of your complaint to the provider when we request a response. It is not legally necessary for you to sign this form; your complaint will be evaluated regardless of whether you sign it. However, it may be easier for the Board to evaluate and resolve your complaint if you do sign it. If you choose not to sign the AUTHORIZATION TO RELEASE COMPLAINT form, and the complaint becomes part of an active investigation, the complaint is classified as confidential data in accordance with the Minnesota Data Practice Act.

RIGHTS UNDER DATA PRACTICES ACT: In accordance with the Minnesota Data Practice Act, information supplied to the Board as part of an active investigation is classified as confidential data. However, the complaint may be disclosed to the Board members assigned to this case, Board staff, consultants retained by the Board, the Attorney General's Office, other licensing officials and, when necessary, the courts. In addition, even if you do not sign the AUTHORIZATION TO RELEASE COMPLAINT form, the substance of the complaint may be disclosed to the provider. Disciplinary actions taken by the Board are public, but they do **NOT** include specific patient names.

Finally, may we again remind you to sign and date the COMPLAINT REGISTRATION form. Please return it and the authorizations, if appropriate, in the enclosed pre-addressed envelope.

The entire complaint resolution process can take a long time, but you will be notified in writing about the Board's decision regarding the resolution of your complaint.

Thank you in advance for taking the time to contact the Minnesota Board of Dentistry. If you should have any questions, please contact me in the Board office at (612) 548-2124 or toll free at 1-888-240-4762.

Sincerely,

Judith Bonnell
Complaint Analyst



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OFFICE USE	
BdFile:	_____
LicNo:	_____
OrigLicDate:	_____
DOB	_____

COMPLAINT REGISTRATION

You may use this form to file a complaint against a dentist, dental hygienist, or a licensed dental assistant. Your complaint may be disclosed to members, employees and consultants of the Minnesota Board of Dentistry and to employees of the Minnesota Attorney General's Office. Under certain circumstances your complaint, or a summary of your complaint, may be disclosed to the person you are complaining against or to other persons who might have information about the matter. It also may be necessary to disclose your complaint and related investigative data to an administrative law judge. You are not legally required to complete or return this form.

Complainant's Name

Name of Dentist/Hygienist/Assistant

Address

Address

City, State, Zip

City, State, Zip

Work Telephone Number

Office Telephone Number

Home Telephone Number

Statement of Complaint

(Please use typewriter or write legibly. Use additional paper if necessary)



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Records Waiver Authorization

TO: Any Doctor, Hospital, Clinic, or Other Institution

Having been informed of my rights under the Minnesota Government Data Practices Act, I authorize you to furnish a copy of my records in your possession to, or allow those records to be inspected and/or copied by the Minnesota Board of Dentistry, its agents, and agents of the Attorney General's Office representing the Board. I further authorize you to testify without limitation as to any and all of your findings and/or treatment referred to in said records. I release you, the Minnesota Board of Dentistry, its agents, and the agents of the Attorney General's Office representing the Board from liability for so releasing said records or so testifying, and I waive any privileges afforded me by the law relating to the disclosure or introduction into evidence of health information.

I also agree to permit and hereby authorize the Board to use my name and/or my records in any legal proceeding arising out of this matter.

A photocopy of facsimile transmittal of this form is as valid as the original.

Complainant's Signature

Address

City, State, Zip

Work Telephone Number

Date



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Records Waiver Authorization

TO: Any Dentist, Dental Clinic, or Other Institution

Having been informed of my rights under the Minnesota Government Data Practices Act, I, _____ (Parent/Legal Guardian), authorize you to furnish a copy of the records of _____ (Child/Patient), in your possession to, or allow those records to be inspected and/or copied by the Minnesota Board of Dentistry, its agents, and agents of the Attorney General's Office representing the Board. I further authorize you to testify without limitation as to any and all of your findings and/or treatment referred to in said records. I release you, the Minnesota Board of Dentistry, its agents, and the agents of the Attorney General's Office representing the Board from liability for so releasing said records or so testifying and waive any privileges afforded to _____ (Child/Patient) by the law relating to the disclosure or introduction into evidence of health information. I also agree to permit and hereby authorize the Board to use the name of _____ (Child/Patient) and/or _____ (Child/Patient) records in any documents related to any legal proceeding arising out of the matter.

Signature of Parent or Guardian

Name of Patient

Relationship to Patient

Patient's Date of Birth

Address

City, State, Zip

Date



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Authorization to Release Complaint

Having been informed of my rights under the Government Data Practices Act, I hereby authorize the Minnesota Board of Dentistry and the Office of the Attorney General to provide copies of my complaint, including any documents I include with my complaint, to the dentist, dental hygienist or dental assistant who is the subject of my complaint. I understand that I am not legally required to sign this form. The purpose of this authorization is to facilitate the investigation of my complaint. This authorization expires one year after this date.

Signature of Complainant

Date