

VENTURA COUNTY MEDICAL ASSOCIATION
601 East Daily Drive, Suite 129 - Camarillo, CA 93010 - (805) 484-6822

PATIENT EXPERIENCE RECORD

MEDIATION COMMITTEE

The Ventura County Medical Association is a non-profit organization of physicians and surgeons, dedicated to maintaining quality care and improving patient relationships. VCMA has a variety of committees volunteering their time toward these goals.

It is necessary that you personally discuss the issue with your physician before VCMA can assist in resolving any dispute. This procedure generally resolves most problems.

If the treating physician is not a VCMA member, our ability to be of service may be limited but, in the interest of improving patient relations, we will still process your complaint. In all cases, and even if your physician is a member of VCMA, the opinion of the Committee is advisory only. VCMA has no power to require you or your physician to accept its advice. By completing and signing this form in the box below, you agree to voluntarily participate in this review.

The Medical Board of California is the only authority in the state that may take disciplinary action against the license of the physician(s) to whom your complaint relates. The toll-free number of the Medical Board is 1-800-633-2322, and the Medical Board is located at 1426 Howe Ave., Ste. 54, Sacramento, CA 95825-3236

ACTION: This matter will be directed to the Mediation Committee for review. You will be advised in writing when they have rendered an opinion. Completion of review normally takes 10-12 weeks.

YOUR NAME _____ PHYSICIAN NAME _____

ADDRESS _____ ADDRESS _____

(CITY) (STATE) (ZIP) _____
TELEPHONE: _____ TELEPHONE _____
(HOME) (WORK)

Date of Treatment: _____ Date you contacted doctor
(MONTH) (DAY) (YEAR) about this dispute _____
(MONTH) (DAY) (YEAR)

Briefly state the problem: (Use the back of this page if necessary. Attach copies of any pertinent documents. Send no originals.)

Authorization: For the purpose of reviewing the above described dispute, I _____
hereby authorize _____, MD to testify as to and reveal any diagnosis, treatment, prognosis, medical records, x-rays or other information which concerns me and relates to the above described dispute to the Ventura County Medical Association. I understand that I have a right to receive a copy of this Authorization.
I also authorize the Ventura County Medical Association to release a copy of this form with any and all attachments to the above physician. This authorization shall be valid until a date two years after the date hereof.

Patient's Signature _____ Date _____