WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Authorization to Release Your Name / Identity

If you are the patient, employee of the institution where the healthcare was provided or a healthcare professional, your identity is confidential pursuant to **RCW 43.70.075**, unless you waive that right. The Medical Commission may not be able to investigate a case without releasing the identity of the patient or the person filing the complaint.

By signing this document, you waive the right to confidentiality and authorize the Medical Commission to:

- Release your identity to the practitioner you filed a complaint against;
- Release your identity to other persons who are reasonably necessary to the investigation;
- Release your identity for use in any related discipline hearing resulting from your complaint.

Your Waiver Authorization

I hereby waive confidentiality and consent to the release of my identity, for the sole purpose of investigating my complaint and pursuing disciplinary/adverse action proceedings.

☐ **Yes** ☐ **No***

Signature: _____ Date: _____

Printed name: _____ (Please include middle initial)

Date of birth: _____

Home Phone: _____ Day Phone: _____

* I understand this denial may impair the Medical Commission's ability to pursue investigation of this matter and any disciplinary actions.

Once you have completed this form, please scan and email it to us at: Medical.complaints@doh.wa.gov

If you do not have access to email, please mail it to:
MQAC Complaint Intake PO BOX 47866 Olympia, WA 98504
Or fax it to: 360-236-2744

If you choose to attach any additional materials to this complaint form, the submitted materials will not be returned to you. If you require more information about the Medical Quality Assurance Commission or how a complaint is processed, please visit our website at www.doh.wa.gov/medical