Riverside County Mental Health Plan
Quality Improvement Coordinator
P.O. Box 7549
Riverside, CA 92513
1-800-660-3570

For Office Use Only:
By: _____ Forward to: _____
Date: 02/12/01
Date Consumer Notified: _____
Outcome: _____

APPEAL/GRIEVANCE REQUEST

This form is used to file an Appeal Request. If you need assistance in completing this form, you can request help from your provider, or calling the Quality Improvement Program at (800) 660-3570 or Patients' Rights at (800) 350-0519, or locally, (951) 358-4600. A signed Release of Information Form needs to be submitted with this appeal request. The appeal request can be submitted to your clinician, the Program Supervisor, or mailed directly to the Quality Improvement Program at the address shown above.

I wish to file: ☐ **Appeal** ☐ **Grievance**

PLEASE PRINT
Your address and phone number are important. We need this information to contact you about the outcome of your Appeal or Grievance.

Your Name: _____

Your Address: _____

Your Daytime Phone: _____

☐ Check here if you are currently a resident of a Medi-Cal funded residential treatment program.

☐ **Check here if you are requesting that your appeal request be processed through the Expedited Appeals Process**

Current Provider: _____

If Applicable, Person Representing You: _____

Their Address: _____

Their Daytime Phone: _____

What is the problem?

What would you like the solution to be?

Whom have you talked to about the problem?

Client (or Client's Representative) Signature **Date**

You will not be subject to discrimination or any other penalty for filing an Appeal or Grievance. Your confidentiality will be protected at all times in accordance with State and Federal law. You may request a State Fair Hearing following the completion of the Appeals or Grievance Process.

Riverside County Mental Health Plan
Authorization for Release of Information from the Medical Record

Client's Last Name First Name Middle Name Date of Birth

Street Address City Zip Code Telephone Number

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I, the undersigned, herby authorize (Name and address of health care service provider with records.)

_____

Health Care Provider Name

_____

Street Address

_____

City State Zip Code

And to: **Riverside County Mental Health Plan**
Quality Improvement (QI)
P.O. Box 7549
Riverside, CA 92513

access to my medical records for the purpose of _____.
I further authorize you to provide such copies thereof as may be requested.

The authorization is subject to the following limitations:

☐ 1. Confined to records regarding treatment for the period from _____
_____ to _____ .

☐ 2. Confined to records regarding admission and treatment for the following

medical condition or injury: _____

_____ .

☐ 3. Confined to the following specified information: _____

_____ .

☐ 4. All medical records.

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate three (3) months from the date of consent without express revocation.

_____

Signature of Client, Legal Guardian, Representative (Please Circle)

_____

Date

_____

Signature of Witness

_____

Date

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure.