



HEALTHCARE PRACTITIONER COMPLAINT FORM

COMPLAINANT/REPORTER

Your Name: CASEY SEAN D.
Last First M.I.
 Address: DC#B03942, A1-112L, NEW RIVER CORRECTIONAL INSTITUTION, 7819 N.W. 228TH STREET
Street Address
RAIFORD FLORIDA 32026
City State Zip Code
 Home Telephone: (781) 294-8501 Work Telephone: (781) 294-8501 Best Time to Call: ANYTIME

SUBJECT OF COMPLAINT

HEALTHCARE PRACTITIONER INFORMATION

Provider's Name: RAPPAPORT MICHAEL E.
Last First M.I.
 Practitioner's Address: 1001 BRICKELL ^{Bay} ~~KEY~~ DRIVE SUITE 2001
Street Address Apartment/Unit #
MIAMI FLORIDA 33131
City State Zip Code
 Home Telephone: () N/A Work Telephone: (305) 373-7106
 Profession: PSYCHOLOGIST (i.e. doctor, dentist nurse, etc.)
 License Number: PY0003542 (if known)

PATIENT INFORMATION

(Complete this section if Patient is not the same as Complainant/Reporter)

Name of Patient: _____
Last First M.I.
 Address: _____
Street Address

City State Zip Code
 Home Telephone: () Work Telephone: ()

YOUR RELATIONSHIP TO PATIENT

Self Parent Son/Daughter Spouse Friend Other Practitioner

*** Legal Guardian/provide court documents

NATURE OF COMPLAINT/REPORT

(Please check all that apply)

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Quality of care | <input type="checkbox"/> Inappropriate prescribing | <input type="checkbox"/> Excessive test or treatment |
| <input type="checkbox"/> Misdiagnosis of condition | <input type="checkbox"/> Sexual contact with patient | <input type="checkbox"/> Failure to release patient records |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Insurance fraud | <input type="checkbox"/> Impairment/medical condition |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Misfilled prescription | <input checked="" type="checkbox"/> Patient abandonment/neglect |
| <input type="checkbox"/> Unlicensed | <input checked="" type="checkbox"/> Problem other than listed above | <u>SEE ATTACHED SUPPLEMENT</u> |

Have you attempted to contact the practitioner concerning your complaint? Yes No Date: 3/15/10 & 5/24/10
 Would you be willing to testify if this matter goes to a formal hearing? Yes No
 If the incident involved criminal conduct, you should contact your local law enforcement authority. Have you contacted your local law enforcement authority? Yes No
 If yes, state the name of the person or office that you contacted. MIAMI STATE ATTORNEY'S OFFICE, ASA JOHN N. PERIKLES. When did you make this contact? JANUARY 9, 2009. Please give case number if available N/A

***NOTE: If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority/Guardianship or Personal Representative.

PLEASE LIST ANY PRIOR AND/OR SUBSEQUENT TREATING PRACTITIONER TO YOUR COMPLAINT

| | | |
|---------------------------|-------------------|--|
| Full Name: <u>NONE</u> | Address: _____ | Telephone Number: _____ |
| | | <input type="checkbox"/> Prior Testing <input type="checkbox"/> Subsequent Testing |
| Full Name: _____ | Address: _____ | Telephone Number: _____ |
| | | <input type="checkbox"/> Prior Testing <input type="checkbox"/> Subsequent Testing |
| Full Name: _____ | Address: _____ | Telephone Number: _____ |
| | | <input type="checkbox"/> Prior Testing <input type="checkbox"/> Subsequent Testing |

WITNESSES (PLEASE GIVE FULL NAME, ADDRESS AND TELEPHONE NUMBER)

| | | |
|-----------------------------------|-------------------|----------------------------|
| Full Name: <u>SEE ATTACHED</u> | Address: _____ | Telephone Number: _____ |
| Full Name: _____ | Address: _____ | Telephone Number: _____ |
| Full Name: _____ | Address: _____ | Telephone Number: _____ |
| Full Name: _____ | Address: _____ | Telephone Number: _____ |

Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, and other documents that will help support your complaint. (attach additional sheets if necessary).
 I have attached copies of medical records, correspondence, contracts, and any other documents that will help support my complaint.

SEE ATTACHED "SUPPLEMENT TO HEALTHCARE PRACTITIONER COMPLAINT FORM" AND APPENDIX WITH SUPPORTING DOCUMENTATION

WHAT WOULD SATISFY YOUR COMPLAINT?

PERMANENT SUSPENSION OF LICENSE

Florida Statute 837.06, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

Signature: Sean Casey Date: June 21, 2010
(Required to file complaint)



Please mail this form to:
Florida Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275

**PATIENT CONSENT FOR RELEASE OF GENERAL MEDICAL PATIENT RECORDS,
INCLUDING: MENTAL HEALTH AND/OR PSYCHOTHERAPY PATIENT RECORDS
AND/OR DRUG AND/OR ALCOHOL PATIENT RECORDS**

This Patient Consent meets the requirements of the Health Insurance Portability And Accountability Act of 1996 (HIPAA Privacy Law), found at 45 CFR, Part 164.

For the purposes of this release, "patient records," include, but are not limited to, complete copies of any records, communication and information with respect to general medical, mental health and/or psychotherapy, and/or drug and/or alcohol related history, diagnosis, progress notes, consultations, examinations, prescriptions, treatments, operative procedures, laboratory and pathological tests and reports, x-rays, admission and discharge reports, and bills.

TO: Any and all treating health care practitioners or facilities.

The undersigned has been fully informed and understands, that certain of the patient records, made and kept in connection with the evaluation and/or treatment of **SEAN D. CASEY**, (the "patient") at or by **DR. MICHAEL E. RAPPAPORT** (the facility or practitioner) on or between **5/10/01 – 5/13/04**, may, under Florida and Federal law, be privileged and confidential, and that the patient, individually or by his/her duly authorized representative, pursuant to the HIPAA Privacy Law, and section 395.3025, F.S., with respect to general medical patient records, section 90.503 and 394.4615, F.S., with respect to mental health and psychotherapy and psychological patient records, and section 397.501, F.S., with respect to drug and/or alcohol related patient records, may refuse to disclose, and prevent the facility or practitioner and any other person from disclosing, such patient records.

Purpose: After being fully informed, and having full understanding of the privileged and confidential status protecting such patient records, the undersigned hereby consents, and authorizes the facility or practitioner, to disclose and release such patient records (or true and correct copies thereof) to the Department of Health and its employees or agents for the purposes of reproduction, investigation or other use for licensure or disciplinary actions, and civil, criminal or administrative proceedings.

By signing below, the patient understands, acknowledges and authorizes the Department to release their identity and medical records to law enforcement and other regulatory agencies in appropriate circumstances and at the discretion of the department.

Re-disclosure: The undersigned acknowledges that such patient records may be subject to re-disclosure by the Department, and may no longer be protected by the federal HIPAA Privacy Law.

Waiver: The undersigned expressly waives any and all rights, claims, and causes of action against the facility or practitioner, their employees, agents or servants, solely and specifically for disclosure and release of the patient's records.



Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

Revocation and Expiration: The undersigned acknowledges that this consent is subject to written revocation at any time to the Department of Health, except to the extent that action has been taken in reliance thereon. In the absence of express revocation, this consent is in effect until related disciplinary proceedings are concluded.

Prohibition on Rediscovery of Drug and Alcohol Treatment Records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SEAN D. CASEY

Patient Name (Please Print)

Sean Casey

Patient Signature

D.O.B.

Social Security Number

6/21/10

Date

Name of Authorized Person other than Patient (Please Print)

Relationship

Signature of Authorized Person Other than Patient

STATE OF FLORIDA

COUNTY OF BRADFORD

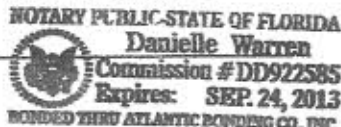
Before me personally appeared SEAN D. CASEY whose identity is known to me by INMATE D.O.C. #B03942 (type of identification) and who acknowledges that his signature appears above.

Sworn to or affirmed by Affiant before me this 21st day of June, 2010.

Danielle Warren
NOTARY PUBLIC - State of Florida

09-24-13
My Commission Expires

Type or Print Name



N/A
Witness Signature (if not notarized)

