ECRMC PATIENT RELATIONS

Patient Feedback Form

Patient Name (please print): _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Phone: _____ Medical Record Number (if known): _____

Submitted by: _____ Relationship to Patient: _____
This concern is regarding my bill: _____Yes _____ No

This concern is regarding my patient care: _____Yes _____ No

Did you discuss this concern with a member of your health care team? _____Yes _____ No

Please write a brief statement:
Who was involved? _____

When did the issue occur? _____

Where did the issue occur? _____

What happened? _____

_____

_____

_____

_____

(Please use back of form if necessary and/or attach related document/s)

I authorize the ECRMC Patient Relations Department to review the above concern and advocate on my behalf. I understand the advocate will review my medical record and/or discuss my case with my ECRMC health care provider(s).

_____ _____

Signature of Patient/Guardian or Authorized Agent **Date**

Please return to: ECRMC Patient Relations, 1415 Ross Ave., El Centro, CA 92243
Telephone: 760-339-7407 | Fax: 760-339-7177 | https://www.ecrmc.org/for-patients/patient-grievances

We understand that you may feel like a complaint to the hospital itself will not be enough to address your concerns. If you would like to discuss your complaint with a third party, you may also contact the **Joint Commission** at 800-944-6610. You also have the option to contact the: **Department of Health Services Licensing and Certification** 7575 Metropolitan Dr., Ste. 211 San Diego, CA 92108 | 866-706-0759 *OR* if your complaint is regarding a physician you may contact the: **Medical Board of California Attention: Central Complaint Unit** 1426 Howe Ave., Ste. 54 Sacramento, CA 95828 | 800-633-2322