

**Personal Health Information Act  
Complaint Form**

This form is provided to you to allow you to provide all information related to your complaint.  
You may also send a letter outlining your complaint to the Personal Health Information Act Contact:

Jan Merrill  
jan@alliancedental.ca

**1. PATIENT/CLIENT/RESIDENT NAME AND CONTACT INFORMATION (please print clearly)**

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Last Name

First Name

Middle Initial

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Mailing Address

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Day time phone number

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E-Mail address (only required if you wish to be contacted by e-mail)

How do you wish to be contacted? Please circle: Phone, Regular Mail, Email

If you are making the complaint on behalf of someone else, please provide your name and contact information:

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Last Name

First Name

Middle initial

Relationship to patient/client/resident \_\_\_\_\_

Mailing address \_\_\_\_\_

Daytime telephone number \_\_\_\_\_

E-mail address (only required if you wish to be contacted that way)

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How do you wish to be contacted? Please check one ☐ Phone ☐ Regular mail ☐ E-mail

You must attach a copy of the document authorizing you to make the complaint.  
Example: written consent of the individual, guardianship documents.

## 2. DETAILS OF THE COMPLAINT

Please provide as much information as you can about the complaint you are making. Please include details of the incident(s) leading to your complaint, the name of any individuals who are involved in the incident(s), the date when it occurred and any information about your efforts to attempt to resolve this complaint outside of the complaint process (i.e. informal discussions with someone involved in the incident).

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Please attach any documents relevant to the complaint

## 3. RESOLVING THE COMPLAINT

What do you think should happen to resolve your complaint?

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## 4. CONSENT AND SIGNATURE

In order to fully investigate your complaint, we will need to review your personal health information relevant to your complaint. Please check and initial your response.

\_\_\_ ☐ I consent to Jan Merrill reviewing my personal health information in order to fully

investigate my complaint.

\_\_\_ ☐ I do not consent to Jan Merrill reviewing my personal health information in order to fully investigate my complaint.

We may also need to discuss the facts presented on this form and any other information related to the complaint with individuals in our organization. We would only disclose information relevant to the complaint.

\_\_\_ ☐ I consent to Jan Merrill discussing the facts presented on this form and any other information related to the complaint with individuals at Millcove Dental]. I understand that Jan Merrill will only disclose information relevant to my complaint.

Please note that we may not be able to fully investigate your complaint if we do not have access to all the relevant information related to your complaint

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Signature

Date:

Please deliver or mail your original form to:

Jan Merrill

Phone: 902-435-0473

Fax: 902-435-5268

**Alliance Dental Dartmouth**

Suite 204, 635 Portland Hills Drive  
Dartmouth, Nova Scotia  
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