Berkeley Mental Health Suggestion/Grievance Form

Your services will NOT be adversely affected in any way by completing this form.

This is a:
- □ suggestion
- □ complaint (grievance)
- □ request for change of provider (My provider is:_____)
- □ request for access to my medical records (copying fee may apply)
- □ appeal hearing (attach complaint response letter)

Please Print. Be specific by giving names, dates and times whenever possible. You may attach additional pages if necessary.

Today's Date _____

1. **What is your complaint/suggestion/request?**

2. **For complaints/appeals only: If you have already done something to attempt to resolve your complaint, what have you done and what were the results?**

3. **What would you like to see happen?**

4. **If you would like to be contacted regarding this matter complete the information below:**

Name:

Address: **City & Zip:**

Phone:

7/07