Lakes Region
Mental Health Center
Promoting Healthy Minds Since 1966

Recipient Rights Complaint

Instructions:

If you believe that one of your rights has been violated - you (or someone on your behalf) may use this form to make a rights complaint.

A Complaint Investigator will investigate your complaint and you will receive a report within 30 days.

Complainant's Name:	Recipient's Name: (if different) ☐ Inpatient ☐ Outpatient
Complainant's Address:	
What right do you think was violated?	
Where did it happen? (name of community agency)	
When did it happen? (Date and time)	
Program where you receive services:	
Name of your therapist (or case manager):	
Describe what happened:	

I understand that a copy of this report will be sent to the State Bureau of Mental Health. Please print, sign, date this form and mail to LRMHC, Attn: Privacy Officer, 140 Beacon Street East, Laconia, NH 03246.

_____/_____ _____/_____

Signature of Complainant *Date* *Signature of Person assisting Complainant (if applicable)* *Date*

Distribution: Rights Officer/Quality Improvement Director, Program Director, Executive Director, Medical Director, Complainant's Copy