MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

Enforcement Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2528
Fax: (916) 263-2435
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

April 22, 2021

Ann Olivarius
200 Park Avenue, Suite 1700
New York, VY 10166

Re: Calvin Hirsch, M.D.
Control #: 800-2020-073226

Dear Ann Olivarius:

We have reviewed your complaint and need to contact you for additional information. Our office is in receipt of the additional information you provided via email on February 02, 2021. The information provided includes sexual misconduct allegations against multiple physicians with patients. You also indicated that your complaint was wrongly closed as our office used the incident date of 1975 in which the alleged sexual misconduct occurred. You further indicate you confronted Dr. Hirsch in 2014.

Our office is contacting you to request the following information: On a separate sheet of paper, please provide the contact information for each patient related to the allegations of sexual misconduct as outlined in your complaint. Please provide a response to the following questions regarding your complaint against Dr. Hirsch and the allegations of sexual misconduct as outlined in your complaint:

Was your relationship with Dr. Hirsch personal or a physician/patient relationship?
Were you ever a patient of Dr. Hirsch? Please provide the dates you were seen by Dr. Hirsch.
Were you being seen by Dr. Hirsch as a patient in December 2014 when the alleged diagnosis occurred?

If you received care and treatment from Dr. Hirsch, the Board is unable to conduct a thorough review of your complaint without obtaining a copy of your medical records. To do so, we must have you complete and sign the enclosed **Authorization for Release of Medical Information** forms. Please complete a medical release form for any health care providers involved in the care you outlined in your complaint, including the complete names and addresses of each physician and facility.

It is important for you to know that the medical release forms will not be valid if they contain any additional comments other than the information requested below. If you have any additional information concerning your complaint, please submit it on a separate sheet of paper. Do not write any comments on the medical release forms. Also, please be advised that, pursuant to Business and Professions Code section 2230.5, the Medical Board must file an Accusation (formal charges against a physician's license) within three (3) years of the date the Board is first notified of the act or omission alleged as the ground for disciplinary action or seven (7) years from the date of the incident, whichever occurs first. As such, if you wish to provide any additional information to the Board that may assist our office in reviewing the treatment provided, please send these documents to us immediately. Documents may include patient records, photographs, audiotapes, correspondence, billing statements, proof of payments, etc.

MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit

The following information must be completed on the enclosed forms (if applicable):

- Date of birth
- Physician/facility: Complete name, address and telephone number
- Treatment date(s) from the listed provider(s)
- Patient's signature, or signature of legal representative and date

If the medical release is signed by someone other than the patient, it may be necessary for the Board to request additional documentation to support the identity of the legal representative. The documentation may consist of one of the following: Power of Attorney for Health Care, Appointment as Executor of the Estate, Will or Trust, a Marriage Certificate, or a Birth Certificate or Custody Documents.

Once the medical release forms are received, your medical records will be obtained and your complaint will be reviewed to determine whether the care provided by Dr. Hirsch was within the standard of practice of medicine.

We would very much appreciate receiving your response by **May 10, 2021**. Please refer to the "Control Number" above when replying.

Sincerely,

Cassie Jones
Consumer Services Analyst
(916) 263-2679

Medical Board of California

Authorization for Release of Information for the Subject of the Complaint

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CHECK ALL RECORD TYPES THAT APPLY

- ☒ Medical Records
- ☒ Diagnostic Images
- ☒ HIV/AIDS
- ☒ Alcohol/Drug Abuse
- ☒ Psychiatric

PATIENT INFORMATION

Patient Name
Ann Olivarius

Date of Birth

Date of Death (If applicable)

Medical Record Number (If known)

Control Number
800-2020-073226

CJ 05/10/2021

Patient Name: Ann Olivarius

I, the undersigned hereby authorize:

Physician/Provider Calvin Hirsch, M.D.		
Street Address		
City	State	Zip Code
Phone Number	Treatment Date(s)	

to disclose medical records in the course of my diagnosis and treatment to the **Medical Board of California, Enforcement Program,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have the right to receive a copy of this authorization if requested by me. I understand that I have a right to revoke this authorization by sending written notification to the Medical Board of California at the above address. My written revocation will be effective upon receipt by the Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or healthcare provider and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

Patient Signature — Date

- OR -

Legal Representative Name — Relationship to Patient

Legal Representative Signature — Date

NOTE: Failure by a physician, podiatrist, or healthcare provider to provide the requested records within 15 days, or a healthcare facility within 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board.

Medical Board of California

Physician/Provider/Facility Authorization for Release of Information

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PATIENT INFORMATION

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Ann Olivarius

Date of Birth

Date of Death (If applicable)

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Control Number
800-2020-073226

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Physician/Provider/Facility		
Street Address		
City	State	Zip Code
Phone Number	Treatment Date(s)	

Physician/Provider/Facility		
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Patient Signature _____ Date _____

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CJ 05/10/2021