Ohio Board of Psychology

77 South High Street, Suite 1830
Columbus, OH 43215-6108
FAX 614-728-7081
PHONE 614-466-8808
psy.enforce2@psy.ohio.gov
psy.enforce@psy.ohio.gov

COMPLAINT FORM

1. COMPLAINT AGAINST:

Name: _____
(Psychologist, School Psychologist, Certified Ohio Behavioral Analyst, Other)

Address: _____
(Location where services were delivered)

2. COMPLAINT FILED BY: (must be signed on page 2)

Name: _____ Maiden name/aliases/former names_____

DOB: _____ Email _____

Phone: Cell: _____ Work: _____ Home: _____

Address: _____

3. DESCRIPTION OF SERVICES RECEIVED:

Dates Services were performed: From: _____ To: _____ (be as specific as possible)

Type of service(s) received (circle all that apply): **Individual Therapy/ Family Therapy/ Marriage Therapy/ Evaluation /Other**

Were you the treatment client or evaluated person? Yes_____ No_____

If "No", please identify the client(s) or evaluated person(s) and your relationship with the person(s):

_____

_____

_____

4. List any materials or documents that you have included relevant to your complaint. Examples might include: psychological reports and/or records; letters; testimony; court orders and/or entries; explanation of benefits, billing records, etc.

_____

_____

5. STATEMENT OF COMPLAINT

On a **separate piece of paper**, please describe the conduct or behavior related to your complaint. Include a sequence of events surrounding your complaint, and the reason for services. Please attach any information that you think will help substantiate your complaint. *FAILURE TO INCLUDE A STATEMENT OF COMPLAINT WILL DELAY THE PROCESSING OF YOUR COMPLAINT. IF YOU NEED ASSISTANCE PLEASE CALL THE BOARD'S OFFICE TOLL FREE AT 1-877-779-7446.*

6. List names and daytime/mobile phone numbers of any individuals who either have knowledge of the improper conduct or may have other relevant information. Briefly describe the information each individual possesses. Please use a separate sheet of paper to list additional people. (It is within the discretion and judgment of the Board whether any or all individuals listed below will be contacted.)

a)_____

_____

b)_____

_____

c)_____

_____

7. Are you currently involved in any administrative, civil or criminal litigation related to the circumstances surrounding your complaint? Yes_____ No_____

If "Yes," please explain:

_____

_____

8. Have you attempted to resolve your concerns through any other avenues? Yes_____ No_____

If "Yes," please explain:

_____

_____

By signing this complaint: I agree to provide a sworn statement concerning my complaint and testify under oath should this matter proceed to a formal administrative hearing; I attest that all information is true and accurate to the best of my knowledge; and I acknowledge that I have received and/or read THE PROCESS OF INVESTIGATION OF YOUR COMPLAINT BY THE STATE BOARD OF PSYCHOLOGY OF OHIO:

_____

Signature of Individual Making Complaint **Date**

Ohio Board of Psychology

INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION
GENERAL RELEASE

I,_____(***name of client, guardian, or parent***), hereby authorize and instruct _____(***name of psychologist, school psychologist, or behavior analyst***) to release and furnish to the Ohio Board of Psychology, its agents and/or legal representatives any and all information related to his or her treatment or evaluation including, but not limited to: all psychological records, diagnoses, prognosis, treatment plans, psychological test reports and raw test data, written statements and/or reports, billing records, and any documentation describing treatment or evaluative services. I further authorize the above referenced license holder to fully cooperate with the Board's investigation by rendering testimony, participating in interviews or otherwise, verbally or in writing, and discussing the services rendered to:

Name of client(s) or patient(s): _____

Relationship (circle all that apply): ***Self/undersigned*** ***Child/ren*** ***Other***

I understand that I may revoke this authorization in writing at any time. Unless revoked in writing, I understand that this authorization is valid for one (1) year from the date of the signature indicated below:

Full Name of Individual Authoring Release: _____

Current Address:_____

Home phone:_____ Cell Phone_____

Email address:_____

Signature:_____ **Date**:_____

Ohio Board of Psychology

INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION PSYCHOTHERAPY NOTES (HIPPA)

I, _____(***name of client, guardian, or parent***), hereby authorize and instruct_____(***name of psychologist, school psychologist, or behavior analyst***) to release and furnish to the Ohio Board of Psychology, its agents and/or its legal representatives any and all information in my record or file, specifically psychotherapy notes as defined in the HIPAA federal guidelines, for services rendered to:

Name of client(s) or patient(s): _____

Relationship (circle all that apply): ***Self/undersigned*** ***Child/ren*** ***Other***

I understand that I may revoke this authorization in writing at any time. Unless revoked in writing, I understand that this authorization is valid for one (1) year from the date of the signature indicated below:

Full Name of Individual Authoring Release: _____

Current Address:_____

Home phone:_____ Cell Phone_____

Email address:_____

Signature:_____ **Date**:_____