THE STATE BOARD OF PSYCHOLOGY OF OHIO
77 South High Street, Suite 1830
Columbus, OH 43215-6108

Telephone: (614) 466-8808 FAX #: (614) 728-7081

COMPLAINT FORM

Form Mailed: _____

Ref #: _____

1. COMPLAINT AGAINST:

Name: _____
(Psychologist, School Psychologist, Other)

Address: _____

_____
(Location where services were delivered)

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

Name: _____ SSN: _____
(voluntary -court rulings prohibit re-disclosure)

DOB: _____ TELEPHONE # _____

Address: _____

_____

3. DESCRIPTION OF SERVICES PERFORMED:

Date Services Performed: From: _____ To: _____

Frequency of Services: _____ (Weekly, Bi-Weekly, Monthly, Etc.)

Time of Appointments: _____
(Weekdays, Evenings, Weekends; Hour of Day When Seen)

Amount Charged: _____
(Hourly or Otherwise)

Amount Paid: _____ Amount Owed: _____

Third Party Payer: _____
(Example: Worker's Comp, Medicaid, Medicare, Private Insurer [name])

4. List any materials or documents that you have included relevant to your complaint.

_____

_____

_____

5. STATEMENT OF COMPLAINT

On a separate piece of paper, please describe conduct or behavior, which you believe to be a violation of applicable Revised Code and Administrative Code sections. Include a sequence of events surrounding your complaint, reason for services, and attach any information that you think will help substantiate your complaint. IF YOU FAIL TO INCLUDE A "STATEMENT OF COMPLAINT" YOUR COMPLAINT CANNOT BE PROCESSED.

6. List Names, Addresses and Phone numbers of any witnesses who either have knowledge of the improper conduct or may have other relevant information. Briefly describe the information each individual possesses.
(It is entirely within the discretion and judgment of the Board whether any or all of witnesses listed below will be contacted.)

a)_____
_____
_____
_____
_____

b)_____
_____
_____
_____
_____

c)_____
_____
_____
_____
_____

7. Have you sought mediation or any other avenue for complaint resolution? If so, please describe:
_____
_____

8. What action would you like the Psychology Board to take?
_____
_____
_____

9. Complainant willing to give a sworn statement concerning the complaint? YES ____ NO ____

10. Releases of Information completed and attached? YES _____ NO _____

By signing this complaint, I assert that all information is true to the best of my knowledge. I also acknowledge that I have received and read THE PROCESS OF INVESTIGATION OF YOUR COMPLAINT BY THE STATE BOARD OF PSYCHOLOGY OF OHIO:

_____
Signature of Individual Making Complaint Date

(KCD 4/2006)

INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION SPECIFICALLY PSYCHOTHERAPY NOTES

TO: _____
(Name)

_____
(Address)

_____
(City, State & Zip)

I,_____, hereby authorize and instruct the above-referenced individual to release and furnish to the **State Board of Psychology of Ohio, 77 S. High Street Suite 1830 Columbus, OH 43215-6108 any and all information in my records or files**, specifically psychotherapy notes as defined in the HIPAA federal guidelines for services rendered to:

Name of Client or Patient: _____

Relationship: Self/Undersigned Child Other _____

I hereby direct the above-referenced licensee to release such information upon request to any agents or legal representative(s) of the State Board of Psychology of Ohio.

This release form is valid for one (1) year from the date of signature indicated below.

Full Name of Individual Authorizing Release:

Current Address:

Telephone Number:

Signature:_____ Date: _____

INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION

TO: _____
(Name)

_____
(Address)

_____
(City, State & Zip)

I, _____, hereby authorize and instruct the above-referenced individual to release and furnish to the **State Board of Psychology 77 S. High Street Suite 1830 Columbus, OH 43215-6108 any and all information**, including but not limited to any and all psychological records, diagnoses, prognosis, treatment plans, psychological test reports and raw test data, statements or reports, billing records, and other documentation and describing treatment or evaluative services. I further instruct the above-referenced individual to fully cooperate with the Board's investigation by rendering testimony, participating in interviews or otherwise, verbally or in writing, discussing the services rendered to:

Name of Client or Patient: _____

Relationship: Self/Undersigned Child Other _____

I hereby direct the above-referenced licensee to release such information upon request to any agents or legal representatives of the State Board of Psychology of Ohio.

This release form is valid for one (1) year from the date of signature indicated below.

Full Name of Individual Authorizing Release:

Current Address:

Telephone Number:

Signature: _____ Date:_____