ARKANSAS BOARD OF HEARING INSTRUMENT DISPENSERS

COMPLAINT FORM

Complaint Filed By:

Name: ____________________________

________________________

Last First Phone #

Address: __________________________________________________________

Number and Street Suite/Apt #

_______________________________________________________________

City State Zip

Hearing Instrument Specialist and/or Hearing Center Information
Please include all known information about the licensee and/or hearing center against whom you would like to file a formal complaint. The licensee will receive a copy of your complaint and will be instructed to respond within twenty (20) days of receipt of the complaint.

Name of Hearing Instrument Specialist _______________________________________

________________________

Last First

Name of Hearing Center _____________________________ Phone __________________

Address _________________________________________________________________

Number and Street Suite/Apt #

_______________________________________________________________

City State Zip

Statement of Complaint
Please identify the reason for your complaint. Check all that apply.

□ Quality of care □ Unlicensed practitioner □ Facility hours □ Hearing aids

Have you contacted the specialist concerning your issue? □ Yes (Date: ________________) □ No

Would you be willing to testify if the complaint goes to a hearing? □ Yes □ No

If the issue is a criminal matter, have you contacted law enforcement? □ Yes □ No
Date of Incident: ________________

What was the purpose of your visit to the Hearing Center (i.e. hearing test, hearing aid repair)?
____________________________________________________
____________________________________________________
____________________________________________________

Did you purchase hearing aids? □ Yes (Date: _____) □ No If yes, how many? □ 1 □ 2

Please explain the incident, providing as much detailed information as possible (use additional paper if needed).
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

Please sign with a witness present and include copies of all documentation supporting your complaint. Be sure to complete the attached HIPAA Authorization Form.

__________________________________________  __________
Signature of Complainant  Date

__________________________________________  __________
Signature of Witness  Date

OFFICE USE ONLY

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<th>Complaint ID:</th>
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HIPAA AUTHORIZATION FORM

I, __________________________________________ hereby authorize the use or disclosure of my protected health information as described below:

1. Authorized persons to use and disclose protected health information:

__________________________________________________________ is authorized to disclose the following protected health information to employees of the Arkansas State Board of Hearing Instrument Dispensers at 4815 W. Markham Slot 2, Little Rock, AR 72205.

2. Description of information to be disclosed:

   The health information that may be disclosed is:

   All medical records, including but not limited to examination records, treatment records, purchase records, and repair records.

   All past, present and future periods of health care information may be shared.

3. Purpose of the use or disclosure:

   The purpose of this use or disclosure is to allow proper investigation of a formally filed complaint.

4. Validity of Authorization Form:

   This Authorization Form is valid beginning on ____________________, and expires on ____________________.

5. Acknowledgement:

   I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization in writing at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

_____________________________________________  ________________________________
Signature of Complainant                      Date