Maryland Department of Health
Board of Examiners for Audiologists,
Hearing Aid Dispensers and Speech-Language Pathologists
4201 Patterson Avenue
Baltimore, MD 21215
Phone: 410-764-4725
TTY/ Maryland Relay Service: 1-800-735-2258

Complaint Form

If there is more than one person filing this complaint, please use a separate form for each person filing the complaint.

1. Full Name of the Complainant:

____

2. Home Address: ____

____

3. Business Address: ____

____

4. Home Telephone: ____________________ Email: _____________________________

5. Date of Birth: ____________________________

6. Name of practitioner about whom you are making this complaint:

____

7. Office Address: ____

____

Office Telephone: ____

8. Were you a patient of this practitioner? ____________________________________

If yes, during what period of time? ____

9. Have you discussed your complaint with the practitioner about whom you are making the complaint?

____

____

____

10. Date(s) of the occurrence(s) of the complaint:

____

____

____

11. Describe with as much detail as possible, the exact nature of your complaint(s) against this practitioner. Use as many additional sheets as necessary. Number each additional sheet and sign the bottom of each page.

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12. Have you make this complaint to any other person or organization? If so, to whom?

____

____

____

13. For what condition were you being treated by this practitioner?

____

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14. Do you consent to the release to this Board or its designated investigating body, of medical reports and records relating to you and to this occurrence from any hospital, related institution or health professional, including the practitioner about whom you are making the complaint?

____

If the complaint is made by a person other that a patient, please furnish the following information:

15. Your official title or designation: ____

16. Did you personally investigate the matter set forth in this complaint? ____________

17. If not, or if others assisted you in the investigation, state the names and titles of the person or persons, if any, who investigated or assisted.

18. Do you have any reports or other written communications directed to you with respect to the matters complained of? If yes, please attach copies of such material to this complaint form.

19. Please state any further information regarding this complaint which you wish to convey to the Board.

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__________________________   ___________________________________

Date of Complaint   Signature of Complainant

Release of Medical Records

I, ____,

do hereby authorize ____
(Name of Health Care Provider)

____

(Address and Phone Number of Health Care Provider)

to release to the Maryland Department of Health, all records relating to your treatment of me during the period of

____

to the present, and permit discussion of the details of the treatment. This release is valid for one year.

___________________________________ ___________________________________

(Date) (Signature)