



**BOARD OF DENTAL EXAMINERS OF ALABAMA**  
**Stadium Parkway Office Center-Suite 112**  
**5346 Stadium Trace Parkway**  
**Hoover, Al 35244-4583**  
**PHONE 205-985-7267**

## **PATIENT COMPLAINT FORM**

You may use this form to file a complaint against a dentist or dental hygienist. Your complaint may be disclosed to members, employees and consultants of the Board of Dental Examiners of Alabama. Your complaint will be disclosed to the person you are complaining against or to other persons who might have information about the matter. It also may be necessary to disclose your complaint and related investigative data to an administrative law judge.

### **INSTRUCTIONS**

- 1) Please fill in the information listed below. Then answer the questions and state your complaint.
- 2) A copy of your complaint will be given to the dentist(s)/ hygienist(s) involved.
- 3) Any person who files a complaint must be willing to appear as a witness, testify and be cross-examined concerning the allegations made in the complaint if asked to do so.

### **IMPORTANT**

*The Board of Dental Examiners of Alabama cannot give legal advice or act as your attorney; nor does the Board have jurisdiction over fee disputes.*

**\*\*Indicates a field required to accept your complaint. Your complaint may be rejected if any portion of a required field is left blank.**

\*\*Your Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

\*\*Home Address: \_\_\_\_\_

\*\*Home Telephone: \_\_\_\_\_

Alt. Phone: \_\_\_\_\_

\*\*Person/ Entity Complaint is against: Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

\*\*Telephone: \_\_\_\_\_

\*\*Address: \_\_\_\_\_

Approximate Dates of Treatment: From \_\_\_\_\_ to \_\_\_\_\_



## Authorization to Release Complaint

I AFFIRM THE PRECEDING AND IT IS TRUE TO THE BEST OF MY INFORMATION AND BELIEF. **I am filing this complaint to notify the Board of the activities of this practitioner so that it will be determined if discipline is warranted. I understand that a copy of this complaint may be provided to the dentist/ hygienist.**

\_\_\_\_\_  
SIGNATURE OF COMPLAINANT/ DATE

### ALL COMPLAINTS MUST BE NOTARIZED.

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ before me personally appeared \_\_\_\_\_ known to me to be the person who is described in and who executed the foregoing instrument, and acknowledged to me that they executed the same.

\_\_\_\_\_  
Notary Public, County of \_\_\_\_\_,

My commission expires: \_\_\_\_\_



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**AUTHORIZATION FOR RELEASE OF RECORDS**

TO: Custodian of Records: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient SSN: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

The undersigned hereby authorizes and approves the release to the Board of Dental Examiners of Alabama or any representative thereof, any and all records and patients' files in your possession which refer, relate or pertain to the above-referenced patient, including, but not limited to the following:

**Patient charts, x-rays, patient histories, health insurance claim forms, group claim forms, pre-estimates, pre-determinations, billing records, account information, invoices, checks, remittance notices, correspondence, notes, memoranda, letters, appointment notices or cards.**

Dated this the \_\_\_ day of \_\_\_\_\_, 20\_\_.

Patient: \_\_\_\_\_

Witness: \_\_\_\_\_



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**AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS**

TO: Custodian of Records: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient SSN: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Contract No.: \_\_\_\_\_

The undersigned hereby authorizes and approves the release to the Board of Dental Examiners of Alabama or any representative thereof, any and all records and patients' files in your possession which refer, relate or pertain to the above-referenced patient, including, but not limited to the following:

**Patient charts, x-rays, patient histories, health insurance claim forms, group claim forms, pre-estimates, pre-determinations, billing records, account information, invoices, checks, remittance notices, correspondence, notes, memoranda, letters, appointment notices or cards.**

Dated this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Patient: \_\_\_\_\_

Witness: \_\_\_\_\_

“The Health Insurance Portability and Accountability Act of 1996 (Act) and the Rules promulgated by the Department of Health and Human Services pursuant to the Act permits disclosure of otherwise protected health information as defined in 45 C.F.R. §160.103 to a 'health oversight agency' without the written authorization of the individual as described in 45 C.F.R. §164.508 or the opportunity for the individual to agree or object as described in 45 C.F.R. §164.510. See 45 C.F.R. §164.512(d)(1). Specifically, this rule provides as follows:

'A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

- (i) The health care system;
- (ii) Government benefit programs for which health information is relevant to beneficiary eligibility;
- (iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or
- (iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.'

A health oversight agency is defined in 45 C.F.R. § 164.501 as follows:

'Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from a contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.”

Since the Board of Dental Examiners of Alabama is a health oversight agency which is authorized by law to seek this information pursuant to the Alabama Dental Practice Act, the disclosure of the requested information is permitted and does not implicate the Act or its rules.”