



**BOARD OF DENTAL EXAMINERS OF ALABAMA**

5346 Stadium Trace Parkway, Suite 112

Hoover, AL 35244-4583

PHONE: (205) 985-7267

Email: [bdeal@dentalboard.org](mailto:bdeal@dentalboard.org)



**COMPLAINT FORM**

To file a complaint against a person holding a license or permit issued by the Board of Dental Examiners of Alabama (BDEAL), please complete the below information. Your complaint will be reviewed by Board personnel to ensure that all required information is provided. Your complaint and any subsequent investigative materials will be reviewed by the Board’s Enforcement Group and, in the case of a formal hearing, may be reviewed by an administrative law judge.

**INSTRUCTIONS**

- 1) Please fill in the contact information listed below.
- 2) Review and answer all questions fully.
- 3) A copy of your complaint may be given to the dentist(s)/hygienist(s) involved for their response.
- 4) 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 needed.
- 5) All complaints must include: the complainant’s name, the name of the person the allegation is against, an allegation(s) that occurred within the last four (4) years, must be notarized.

**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.*

**COMPLAINANT**

(This can be the patient, patient’s guardian or another practitioner)

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

**Home Address:** Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

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

**DENTIST/DENTAL HYGIENIST**

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

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

**Address:** Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Date(s) of allegation/event that your complaint is regarding:** \_\_\_\_\_



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**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

**If you are the patient/or patient’s guardian:**

- 1) Are you willing to appear at a hearing, if necessary?      **YES** \_\_\_\_\_      **NO** \_\_\_\_\_
- 2) Have you received treatment from any other practitioner(s) prior to or after the event in this complaint?  
**YES\*** \_\_\_\_\_      **NO** \_\_\_\_\_

\*If yes, please provide name, address and phone number of the practitioner(s) in your description below or on a separate sheet.

**If you are a practitioner:**

(Answer these questions in your description below.)

- 1) Have you discussed your concerns with the dentist/dental hygienist the complaint is against?
- 2) If your complaint is regarding dental treatment, was the patient seen by other practitioners?
- 3) Have you personally rendered treatment to the affected patient?

**DESCRIPTION OF COMPLAINT**

Please describe your complaint in detail below, to include: any services or procedures provided by the dentist/hygienist; dates/times of the reported event; any perceived unprofessional or prohibited activity by the practitioners(s). Additionally, attach any related documents that support your complaint, if available.

If you need more space, please use additional pages. You may also type/write your complaint on a completely separate page and attach to this form.

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**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 PATIENT RECORDS**

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

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 patient's 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 of \_\_\_\_\_

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 patient's 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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### HIPAA Act of 1996-Permitted Disclosures

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 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.