



## Ohio State Chiropractic Board

77 S. High Street, 16<sup>th</sup> Floor ♦ Columbus, OH 43215-6108

Phone: (614) 644-7032 ♦ Fax: (614) 752-2539

Website: [www.chirobd.ohio.gov](http://www.chirobd.ohio.gov) ♦ Email: [OSCB.chirobd@chr.state.oh.us](mailto:OSCB.chirobd@chr.state.oh.us)

### COMPLAINT FORM

**Please complete this form and the records release form and return both documents along with a synopsis of your complaint to the address listed above. Attach copies of any supporting documentation if applicable.**

Once your complaint is filed, your allegations will be reviewed to determine if a possible violation of the Board's laws and rules has occurred. You will receive a letter acknowledging receipt of your complaint. Depending on the nature of the complaint, a Board Investigator may contact you for further information or for a formal interview. Please understand that the disposition of the matter may take several months or longer, depending on the type of complaint.

The Board does not investigate complaints that involve disputes pertaining to insurance benefits/reimbursements or fee disputes between you and your chiropractic physician. We also do not mediate disputes or determinations pertaining to disability compensation.

If you have any questions regarding this form or about the Board's investigative process, please contact us at 1-888-772-1384.

### COMPLAINANT INFORMATION (please print)

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

May we contact you at work?  Yes  No Best time to call: \_\_\_\_\_

### SUBJECT OF COMPLAINT

Name of Chiropractic Physician: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Clinic Phone: \_\_\_\_\_ Dates of Treatment/Service: \_\_\_\_\_ To: \_\_\_\_\_  
Month/Year Month/Year



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## RECORDS RELEASE FORM

I hereby consent and authorize the release to the Ohio State Chiropractic Board or its Agents any and all records pertaining to me in the possession of:

\_\_\_\_\_  
(Name of Chiropractic Physician)

The information sought is connected with an administrative investigation and/or licensure and disciplinary actions and therefore excepted from patient non-disclosure under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) pursuant to 45 C.F.R. § 164.501.

Patient's Name: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

(If patient is a minor) Parent/Guardian Name: \_\_\_\_\_

(If patient is a minor) Parent/Guardian Signature: \_\_\_\_\_

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_