ARKANSAS BOARD OF HEARING INSTRUMENT DISPENSERS

4815 West Markham St. Slot 2
Little Rock, AR 72205
Office: (501) 661-2051
E-Mail: ar.hid.board@arkansas.gov

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). ____

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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

Complaint ID:	
Received:	
Mailed:	
Response Received:	
Action Taken:	

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