



**ARKANSAS BOARD OF HEARING INSTRUMENT
DISPENSERS**

4815 West Markham St. Slot 2
Little Rock, AR 72205
Office: (501) 203-4032
E-Mail: arhidboard@gmail.com

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 fifteen (15) 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).

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 2701 S. Caraway Rd. Suite A1, Jonesboro, AR 72401.

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