WEST VIRGINIA BOARD OF OPTOMETRY

179 Summers Street, Suite 231 ● Charleston, WV 25301 ● Phone: 304-558-5901 ● Fax: 304-558-5908 ● Email: info@wvbo.org

COMPLAINT FORM

Please see W.Va. State Code §30-8-18 and W. Va. St. R. §14-4 for the WV Board of Optometry Complaint Process and Procedures

1. Complaint is filed ***against***:

   Name: _____ Phone: (_____)_____

   Street Address: _____

   City: _____ State: _____Zip Code: _____

   Date of Care: _____

2. Person ***filing*** complaint (complainant):

   Name: _____ Phone: (_____)_____

   Street Address: _____

   City: _____ State: _____Zip Code: _____

   E-mail Address: _____

3. Complainant's ***relationship*** with the person against whom complaint is being filed: _____

4. ***What is the complaint*** (in your own words: who, what, where, when, why and how):

_____

_____

_____

_____

_____

_____

_____

_____

(Attach additional sheets, if needed, and enclose any supporting documents.)

5. ***Other person(s)*** with knowledge of incident(s) giving rise to this complaint. Include **any practitioner or institution** giving follow-up care. Attach additional sheets, if needed.

   Name: _____ Phone: (_____) _____

   Street Address: _____

   City: _____ State: _____ Zip Code: _____

   E-mail Address: _____

   Name: _____ Phone: (_____) _____

   Street Address: _____

   City: _____ State: _____ Zip Code: _____

   E-mail Address: _____

6. Have you advised any ***other regulatory or legal authority*** of this complaint, (i.e.: the Attorney General's office)?

   _____

   _____

   _____

7. ***What action***, if any, are you seeking from the Board?

   _____

   _____

   _____

   _____

   _____

_____ _____

Complainant Signature **Date**

Completed and signed complaint forms can be scanned and emailed to: info@wvbo.org or mailed to:
West Virginia Board of Optometry 179 Summers Street, Suite 231, Charleston, WV 25301

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AUTHORIZATION FOR RELEASE OF MEDICAL OR SALES RECORDS

PATIENT NAME: _____

I _____, hereby request and authorize:
PATIENT NAME

DOCTOR'S NAME: _____

PRACTICE NAME: _____

ADDRESS: _____

PHONE: _____

To release copies of my complete medical record, and any and all other information regarding my diagnosis, testing and/or treatment that is maintained by _____, (Licensee for whom the complaint is filed against) to the **WEST VIRGINIA BOARD OF OPTOMETRY**, 179 Summers Street, Suite 231, Charleston, WV 25301.

I understand that this authorization may be revoked at any time, except to the extent action has been taken prior to revocation. This consent will expire in sixty (60) days after the date signed below or sooner at my election. I acknowledge that I have read and understand this authorization as it applies to me.

Patient's Signature: _____ Date: _____