STATE OF IDAHO

BOARD OF DENTISTRY

COMPLAINT FORM

I. GENERAL INFORMATION.

Your Full Name (print or type): _____

Street Address: _____

City, State and Zip Code: _____

Home Telephone No.: _____ Work Telephone No.: _____
Facsimile No.: _____

II. LICENSEE (DENTIST OR DENTAL HYGIENIST) COMPLAINED AGAINST.

Name of Licensee: _____

Licensee's Street Address: _____

Licensee's City, State and Zip Code: _____

III. OTHER LICENSEES WHO PROVIDED PRIOR OR FOLLOW-UP TREATMENT OR SECOND OPINIONS IN CONNECTION WITH YOUR COMPLAINT.

Name of Prior or Follow-up Licensee: _____

Follow-up Licensee's Street Address: _____

Follow-up Licensee's City, State and Zip Code: _____

Name of Prior or Follow-up Licensee: _____

Follow-up Licensee's Street Address: _____

Follow-up Licensee's City, State and Zip Code: _____

IV. EXPLANATION OF COMPLAINT.

Please explain your complaint as clearly as possible. **Use additional pages as necessary in order to provide a complete explanation.** If available, please enclose copies of any dental or other records that you feel will be helpful in the explanation of your complaint. Please make your complaint as legible as possible to avoid any delay in the complaint process.

By signing this complaint form, I certify that the information provided is true and correct to the best of my knowledge. I authorize the Board of Dentistry to provide my complaint to the licensee being complained against.

DATED: _____ SIGNATURE: _____

STATE OF IDAHO

BOARD OF DENTISTRY

AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

I hereby authorize and direct any dentist, physician, or other person who provided dental and/or medical care to _____ (patient name), during _____, 20___ to _____, 20___, to release and disclose any and all dental and/or medical records, reports and information to the Idaho State Board of Dentistry or to such other representative of the Idaho State Board of Dentistry as may be designated, for examination and copying thereof, upon request for such records, reports or information for the specific purpose of addressing concerns relevant to my dental care and treatment.

I further authorize and direct any dentist, physician or other person or entity who has such information to consult with or discuss such information with any of the above entities or persons.

If the dental and/or medical records, reports and information to be disclosed relate to a person other than the undersigned, by execution hereof the undersigned acknowledges that he/she has the legal authority to provide a valid consent for disclosure.

I further consent that a photocopy of this Authorization may be used in lieu of the original hereof and shall be considered valid for one (1) year from the date of my signature below. This authorization, however, is revocable upon receipt of my written request by the Idaho State Board of Dentistry.

Dated this ____ day of _____, 20___.

_____
(Printed Name)

_____
(Signature)