Alabama Board of Examiners for Speech-Language Pathology and Audiology (ABESPA)

PO Box 304760
Montgomery, Alabama 36130-4760
Telephone: (334) 269-1434 Fax: (334) 834-9618
Web address: www.abespa.org Email: abespa@mindspring.com

Complaint Form

Individual Registering Complaint

Name _____ Telephone _____

Address _____

City and State _____

Is this complaint being filed on behalf of an agency, corporation, or institution? If yes, please specify:

_____

Individual Against Whom Complaint Is Being Filed

Name _____ Telephone _____

Address _____

City and State _____

Is the individual against whom this complaint is filed licensed by this Board? _____

Nature of Complaint (Please check all that apply.)

- ☐ Administrative/Record Keeping
- ☐ Advertising
- ☐ Fees/Billing Practices
- ☐ Fraud
- ☐ Incompetence
- ☐ Professional Misconduct
- ☐ Sexual Misconduct
- ☐ Substance Abuses/Impairment
- ☐ Unlicensed Practice
- ☐ Other _____

Details of Complaint

Include specific details such as names of people involved, dates, location, information about the alleged violation(s), and any other pertinent facts. Complaints cannot be accepted without an original signature. Please sign and date each page if additional pages are necessary.

Are you aware of any action that has been taken relative to this matter, prior to the filing of this complaint? If yes, please specify:

Signature: _____ Date: _____

Complaints cannot be accepted without original signature

Waiver of Anonymity

I, _____, having made a formal complaint to the Alabama Board of Examiners for Speech-Language Pathology and Audiology (ABESPA), waive my anonymity to assist in the investigation of my complaint. I understand that ABESPA may have to reveal my identity to fully investigate the complaint. I will not hold ABESPA, its members, or employees liable for the release of my identity.

Signed this the _____ day of _____, 20_____.

_____

Complainant

AUTHORIZATION FOR DISCLOSURE/REQUEST OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name _____ Date of Service _____

SSN _____ Sex _____ Race _____ Date of Birth _____

Address _____ City _____

State _____ Zip _____ Phone Number(s) _____

I authorize the disclosure/request of the named individual's health information as described below. The following individual or organization is authorized to make the disclosure/request:

Individual or Organization Name_____

Address _____ City _____

State _____ Zip _____ Phone Number(s) _____

This information may be disclosed to/requested from and used by the following organization:

Alabama Board of Examiners for Speech-Language Pathology and Audiology (ABESPA)
400 S. Union Street, Suite 435, Montgomery, AL 36130-4760, Telephone (334) 269-1434

The Alabama Board of Examiners for Speech-Language Pathology and Audiology (ABESPA) does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.

The type and amount of information to be disclosed/requested is as follows:

☐ Complete Medical Record
☐ Audiological Evaluation & Services
☐ Speech-Language Evaluation & Services
☐ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from date signed.

I understand that authorizing the disclosure/request of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR Part 45 d 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information or to present my written revocation authorization I can contact: *Alabama Board of Examiners for Speech-Language Pathology and Audiology (ABESPA), 400 S. Union Street, Suite 435, Montgomery, AL 36130-4760, Telephone (334) 269-1434.*

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness