



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
UNIFORM COMPLAINT REPORT

MISSOURI STATE BOARD OF OPTOMETRY
 3605 MISSOURI BOULEVARD • PO BOX 1335
 JEFFERSON CITY, MISSOURI 65102-1335

TYPE OR PRINT WITH BLACK INK

Missouri Statutes 565.060 — False Official Statements, Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a Class B misdemeanor.

Please complete this form and return to: **Missouri State Board of Optometry**, 3605 Missouri Boulevard, P.O. Box 1335, Jefferson City, Missouri 65102-1335.

COMPLAINANT INFORMATION

COMPLAINANT NAME	PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S DATE OF BIRTH	TELEPHONE (HOME)
PATIENT NAME			TELEPHONE (BUSINESS)
ADDRESS (STREET, CITY, STATE, ZIP)			

SUBJECT OF COMPLAINT

OPTOMETRIST NAME AND/OR COMPANY	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)	

DETAILS OF COMPLAINT

Give full details of complaint. Include facts, details, dates. Please attach copies of all bills, documents, records, correspondence, and contracts. (Use enclosed Voluntary Statement forms as continuation sheets, if necessary.)

▶ _____

Have you contacted the optometrist concerning this complaint? If so, date ▶ _____ YES NO

Do you presently have an outstanding bill from the optometrist against whom you are complaining? YES NO

Amount ▶ _____

Have you seen and/or been treated by a different optometrist before or after the treatment rendered by the optometrist against whom you are complaining? YES NO

If yes, please give names and addresses.

BEFORE ▶ _____

AFTER ▶ _____

Do you know of any other patients who have had similar problems with the optometrist against whom you are complaining? YES NO

If yes, please give names, addresses and phone numbers (if known to you)

COMPLAINANT'S SIGNATURE	DATE	SIGNATURE OF WITNESS	DATE
ADDRESS OF WITNESS			



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
UNIFORM COMPLAINT REPORT
VOLUNTARY STATEMENT (CONTINUATION SHEET)

MISSOURI STATE BOARD OF OPTOMETRY
 3605 MISSOURI BOULEVARD • PO BOX 1335
 JEFFERSON CITY, MISSOURI 65102-1335

NAME OF PERSON GIVING STATEMENT	PAGE _____ OF _____
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STATEMENT

I have made the foregoing statement of my own free will, without any threats or promises being made; it is true and correct to the best of my knowledge and recollection.

SIGNATURE OF PERSON GIVING STATEMENT	DATE
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NOTARY PUBLIC EMBOSSER SEAL	STATE OF _____	COUNTY (OR CITY OF ST. LOUIS)	
	SUBSCRIBED AND SWORN BEFORE ME, THIS _____ DAY OF _____ YEAR _____		
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	USE RUBBER STAMP IN CLEAR AREA BELOW.
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		



**UNIFORM COMPLAINT REPORT
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH
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- I authorize the use and disclosure of protected health information as described below; and,
- Authorize and request: _____
(NAME OF HEALTH CARE PROVIDER)
- TO RELEASE THE FOLLOWING INFORMATION: Any and all billing records; medical records charts; medical reports; chart notes; clinical notes; x-rays and/or radiographic studies and reports of the same; reports of consultation; patient histories/patient questionnaires; reports and records of laboratory testing and other testing; any and all correspondence (in any format) and any other records and documents contained in my file; or, if applicable, for each admission, whether In-Patient, Out-Patient, or Emergency Room, the entire record for each admission, to include admitting history and physical; discharge summary; reports of consultation; reports and records of laboratory testing and other testing; reports of consultation; x-rays and radiographic studies and reports of the same; and other records and documents for each admission;
- Covering all past, present, and future periods of healthcare; OR
 Covering the period of healthcare from _____ to _____
- The requested information is to be released to the Missouri State Board of Optometry, P.O. Box 1335, Jefferson City, MO 65102.
- The requested information is to be used or disclosed for the purpose of oversight activities authorized by law, including audits; civil, administrative, or criminal investigations, inspections, licensure, or disciplinary proceedings or actions; or other activities necessary for the CIU or entities subject to government regulatory programs for which information is necessary for determining compliance with program standards.
- This authorization shall be in force and effect and not expire until (a) I exercise my right of revocation, as described below, (b) the occurrence of the following date/event _____, or (c) one year from the date of execution, whichever occurs first. A photocopy of this authorization is as valid as an original.
- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so by communicating in writing, with specific reference to this authorization, to the health care provider named in paragraph 2 above, and to the CIU. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that I may refuse to sign this authorization. I further understand that the health care provider named in paragraph 2 may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.
- I understand that after information is disclosed pursuant to this authorization, it is possible that the information may be redisclosed by the recipient and would no longer be protected by applicable medical privacy laws.
- I understand that the information in the requested health record may include information relating to Hepatitis B or C, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). I may also contain information about behavioral or mental health services, psychiatric and/or psychological evaluation testing and/or treatment, and treatment for alcohol and drug abuse.
- I understand that any information disclosed pertaining to alcohol/drug abuse is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of such information from making any further disclosure unless further disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of such information to criminally investigate or prosecute any alcohol or drug abuse patient.

SIGNATURE OF PATIENT, PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
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RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (OPTIONAL)
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NOTARY (OPTIONAL)			
NOTARY PUBLIC EMBOSSEER SEAL	STATE OF	COUNTY (OR CITY OF ST. LOUIS)	
	SUBSCRIBED AND SWORN BEFORE ME, THIS		USE RUBBER STAMP IN CLEAR AREA BELOW.
	DAY OF	YEAR	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
NOTARY PUBLIC NAME (TYPED OR PRINTED)			