JOE LOMBARDO
Governor

STATE OF NEVADA

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Director

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Deputy Directors

MERLE LOK
Executive Director

DEPARTMENT OF BUSINESS AND INDUSTRY
OFFICE OF NEVADA BOARDS, COMMISSIONS AND COUNCILS STANDARDS
NEVADA STATE BOARD OF ORIENTAL MEDICINE

COMPLAINT FORM

NRS 634A authorizes the Board of Oriental Medicine ("Board") to investigate allegations against persons under the Board's jurisdiction. Please complete the Complaint Form and mail it to the office with any relevant information and supporting documentation that may substantiate any violations under the purview of the Board. In order for disciplinary action to be taken, your allegations must fall within the provisions set forth in NRS 634A and/or NAC 634A.

COMPLAINANT INFORMATION (Person filing the complaint):

Name:_____

Address: _____

City: _____State: _____ Zip Code:_____

Email: _____

Phone:_____Fax:_____

RESPONDENT INFORMATION:

Name:_____

Address: _____

City: _____State: _____ Zip Code:_____

Email: _____

Phone:_____Fax:_____

COMPLAINT NARRATIVE (Please describe the relevant details of the complaint in detail you witnessed or of which you have direct and personal knowledge, including dates, times and locations). You may use additional sheets and provide supporting documentation, including notarized statements of any witnesses. Please write legibly or attach typewritten pages.

Have you discussed this issue with the Respondent? If yes, please detail the response. If not, please explain.

OTHER INVOLVED AGENCIES (Please attached additional sheets if necessary)

Agency Name:_____

Name of Contact Person: _____

Address: _____

City: _____State: _____ Zip Code:_____

Email: _____

Phone:_____Fax:_____

DECLARATION

I, _____, being duly sworn, hereby declare under penalty of perjury, that I have written the foregoing complaint and that the information provided in this document is true and accurate to the best of my knowledge.

Signature:_____ Date: _____

NEVADA STATE BOARD OF ORIENTAL MEDICINE

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

To Whom It May Concern: I,_____ , date of birth _____, hereby authorize and direct the following persons/entities at _____ (Print name of Respondent's Office) to furnish to the NEVADA STATE BOARD OF ORIENTAL MEDICINE, any and all medical records pertaining to me, for any and all dates of treatment. The disclosable documents include but are not limited to: Any and all medical records; consultation reports; records of treatment; office notes; treatment plans; clinical notes; informed consents; prescription information; intake forms; documentation of telephonic discussions and/or messages; correspondence; consultation reports; referrals; lab reports; drawings or sketches; risk assessments; test results and reports; all x-ray films and reports; MRI scans and reports; CT scans and reports; any and all diagnostic imaging films, tests and their associated reports; bills, invoices, ledgers and statements reflecting all charges and payment history including benefit payments and/ or patient payments, patient co-payments or deductibles, adjustments, write-offs or discounts; any charges turned over to collections; all documents contained in the patient's electronic or paper chart; and all documents referenced in the Notice of Complaint & Request for Records letter. I authorize the NEVADA STATE BOARD OF ORIENTAL MEDICINE to obtain the above records on my behalf. I authorize the NEVADA STATE BOARD OF ORIENTAL MEDICINE to use the above records in any investigation and/or public hearing conducted by the NEVADA STATE BOARD OF ORIENTAL MEDICINE, its attorney, or any agent, representative, investigator, or expert thereof. This release authorizes the NEVADA STATE BOARD OF ORIENTAL MEDICINE, its attorney, or any representative, agent, investigator or expert thereof to see, copy, or utilize the above records regarding the patient's condition, treatment, and any and all information or opinions pertaining thereto. I understand that I may revoke this authorization to the extent allowed by law but understand that, prior to the provider's receipt of a revocation, the provider is not prohibited from the release of information in reliance on my original authorization. I understand that once my health information is released pursuant to this authorization, the NEVADA STATE BOARD OF ORIENTAL MEDICINE may re-disclose it as required or necessary pursuant to Federal or State law. A copy of this authorization is as valid as an original and shall have the same force and effect as the original.

_____

Signature of Complainant Date Signed

_____

Print Name Phone number

* Note, the Effective Date of this release is the date signed. The release expires either one year from the date signed, or on the date the Board voted on final resolution of the Complaint, whichever date comes last.