Ohio Chemical Dependency Professionals Board
77 South High Street, 16th Floor
Columbus, OH 43215
614-387-1110 phone (614) 387-1109 fax
www.ocdp.ohio.gov **credentialing@ocdp.state.oh.us**

ETHICS COMPLAINT FORM

This form is to be used to file an ethics complaint against a Chemical Dependency Counselor (CDCA, LCDC II, LCDC III or LICDC) or a Prevention Specialist (RA, OCPSA, OCPS I or OCPS II). Including your name, address and phone number is optional. However, it is necessary if you wish to be notified regarding the progress of this complaint.

PERSON FILING THE COMPLAINT:

Your Name: _____

Address: _____

Address: _____

Telephone: _____

Email: _____

COMPLAINT FILED AGAINST:

Name: _____

Employer: _____

Address: _____

Address: _____

Have you voiced your complaint to the employer or facility and/or followed their internal grievance process?

☐ Yes ☐ No

If yes, what was the outcome?

Please describe the conduct or behavior which is the basis for your complaint. Please include the dates the conduct occurred and any other pertinent facts. Please provide as much detail as possible. Attach additional sheets as necessary.

Please list other persons who might have information pertinent to your complaint:

Name: _____

Address: _____

Address: _____

Telephone: _____

Name: _____

Address: _____

Address: _____

Telephone: _____

By signing this complaint, I assert that all information is true to the best of my knowledge.

Your Signature: _____ Date: _____

Authorization for Release of Information

1. Client Name:_____

   Date of Birth: _____ Phone: _____

2. I authorize _____ to release information to:

   The Ohio Chemical Dependency Professionals Board
   77 S. High Street – Floor 16
   Columbus, OH 43215
   (614) 387-1110

3. Date(s) of service (Month, Day & Year to the best of your knowledge): _____

4. **Specific information to be released:**

   ☐ History & Physical Exam
   ☐ Psychiatric/mental health evaluation
   ☐ Treatment Plan
   ☐ Progress Reports
   ☐ Discharge Plan
   ☐ Other (Specify): _____

5. Reason for disclosure: _____

6. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

Signature: _____ Date: _____
(Client/Legal Guardian/Parent)

Witness: _____ Date: _____

This information has been disclosed to you from records protected by Federal Confidentiality rule. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

Your healthcare or payment for care will not be affected by whether you sign this authorization.

A photocopy or facsimile of this authorization will have the same authority as the original.

Revocation of Release of Information

I hereby withdraw my consent for this release of information:

Date: _____ Signature: _____