



Complaint Form/Request for Review

OREGON BOARD OF OPTOMETRY

By law, the Oregon Board of Optometry must investigate every complaint under its jurisdiction that is received. This form may be used to file a complaint or otherwise request that the Board review the professional services of optometric physicians licensed in the state. All information provided by you is optional, and will be held confidential. Please provide as much information as possible to enable the Board to conduct a complete investigation. You will receive a letter from the Board confirming it has received your complaint/request for review and what to expect during the investigation.

For the Board to fully investigate this matter, it may be necessary to request information about the patient from the health care professionals listed. Please also complete the *Patient Health Information Release Authorization*, included below.

If you believe your eye health is at risk, please consult a medical professional immediately.

If you have questions, please contact the offices of the Board at 503-399-0662.

Information about the patient:

Name of Complainant (your name):

First: _____ Middle: _____ Last: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Phone: Home: _____ Cell: _____ Work: _____

E-mail address: _____

Is the patient a minor and you are the parent or legal guardian? If so, list the child's legal name and your relationship to the patient: _____

Patient's date of birth: _____ Patient's gender: Female Male

Does the patient have health conditions or take medications that are relevant to this investigation? If so, please list: _____

Please check all boxes that apply regarding the nature of your complaint:

- Substandard care (misdiagnosis, negligent treatment, delay in treatment, etc.)
- Unprofessional Conduct (breach of confidentiality, record alteration, fraud, misleading advertising, arrest, etc.)
- Office practice (failure to release optometric records or prescription to patient, etc.)
- Physician/provider impairment (drug, alcohol, mental, physical)
- Sexual misconduct/boundary violations (sexual contact, inappropriate touching, remarks, etc.)
- Unlicensed provider, or aiding/abetting unlicensed practice
- Other: _____

Information about the optometrist who provided the professional services:

Name: _____

Office address: _____

City: _____ State: _____ ZIP: _____

Date of initial office visit/examination relating to this request for review: _____

Why did you seek optometric services at this visit? _____

What optometric care was provided (select all that apply):

- Comprehensive eye examination Prescription eyeglasses Contact lenses
- Visual training (eye exercises) Low-vision aids Other _____

Explain in detail the specific difficulty/dissatisfaction you are having with the optometric care provided (you may attach a written explanation): _____

Patient Health Information Release Authorization

To the Oregon Board of Optometry

I authorize the Oregon Board of Optometry or any designated representative of the Board to communicate with any optometrist, physician, or other person who may be able to aid and assist in my request for evaluation of professional services and obtain information that may assist the Board in the evaluation.

I further authorize any optometrist, physician, or other person to disclose and release all information relating to me that may assist the Board in conducting an evaluation of professional services.

I understand that the Board will hold this information confidential as required by Oregon and federal laws and rules.

Printed name of patient: _____

Signature of patient or parent/guardian: _____

Date: _____



Oregon Board of Optometry
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(503) 399-0662