Request for Review of Professional Services
OREGON BOARD OF OPTOMETRY

By law, the Board must investigate every complaint under its jurisdiction that is received. This form may be used to file a complaint or otherwise request that the Oregon Board of Optometry 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 request for review/complaint and what to expect during the investigation. The Board does not investigate or take action on fee disputes.

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*, 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, ext. 1000.

Information about the patient:

Review requested by: _____
(Please print name) *First* *Middle* *Last*

Mailing address: _____

City: _____ State: _____ ZIP: _____

Phone: Home: _____ Cell: _____ Work: _____

Email 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: _____

_____

_____

_____

_____

Information about the optometrist who provided the professional services:

Name: _____

Mailing 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 _____

What advice or instructions were you given regarding the optometric care provided? _____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

Did you return to this doctor regarding your difficulty/dissatisfaction? ☐ Yes ☐ No

Have you seen another doctor of optometry, ophthalmologist or other health care professional regarding your difficulty/dissatisfaction with the optometric care you received? ☐ Yes ☐ No

If Yes, please provide the name and address of the other health care professional(s) seen:_____

_____

_____

_____

What action do you desire to resolve your difficulty/dissatisfaction? _____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

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: _____

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