WEST VIRGINIA BOARD OF DENTISTRY
PO Box 1447
Crab Orchard, WV 25827
PHONE: (304) 252-8266 TOLL FREE (877)914-8266
FAX: (304) 253-9454
wvbde@suddenlinkmail.com

COMPLAINT FORM

Name of Dentist or Dental Hygienist:_____

Address:_____ Email:_____

_____

Name of person filing complaint:_____

Address:_____

_____

Daytime Phone:_____ Alternate Phone:_____

Patient's first and last name if other than person filing complaint:

_____

Patient's Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Son/Daughter ☐ Spouse
☐ Other _____

Date of Treatment: _____

PLEASE NOTE:

The West Virginia Board of Dentistry regulates the practice of dentistry and dental hygiene in West Virginia. The Board can discipline a licensed dentist or dental hygienist who violates the law or deviates from the standard of care for dentistry. **The Board has no jurisdiction over billing or fee disputes, insurance coverage, personality conflicts, scheduling issues, or employee/employer disputes.**

In order to ensure procedural due process, this complaint will be shared with the dentist or dental hygienist for his or her response. **ONCE COMPLETED, YOUR SIGNED COMPLAINT IS A MATTER OF PUBLIC RECORD.**

NATURE OF COMPLAINT IN DETAIL: Please type or clearly print your concerns or explain the issues involved in your complaint. Attach additional pages and supporting documentation as necessary.

PLEASE LIST ANY PRIOR AND/OR SUBSEQUENT TREATING PRACTITIONERS RELATIVE TO YOUR COMPLAINT.

Name:_____ ☐ Prior treating ☐ Subsequent
Address:_____
_____

Name:_____ ☐ Prior treating ☐ Subsequent
Address:_____
_____

Name:_____ ☐ Prior treating ☐ Subsequent
Address:_____
_____

By signing this complaint form, I hereby certify that the information provided is complete and true to the best of my knowledge. Further, I will voluntarily appear and testify to the facts in this complaint if called upon by the West Virginia Board of Dentistry.

Date:_____ Signature: _____
Patient or Legal Guardian

Please sign the release on the next page and return with your complaint form. Failure to sign and return the release may result in a delay of the investigation of your complaint.

FOR OFFICE USE ONLY

Complaint No.: _____ Date Received: _____

License No.: _____ Receipt Letter Sent: _____
Licensee Letter Sent: _____ Violation: _____

Disposition: _____ Disposition Date: _____

WEST VIRGINIA BOARD OF DENTISTRY

RELEASE OF DENTAL/MEDICAL RECORDS
FROM DENTAL/MEDICAL PROVIDERS OR FACILITIES AND
AUTHORIZATION TO RELEASE SUCH RECORDS TO THIRD PARTIES

I, the undersigned, hereby authorize and direct release to the West Virginia Board of Dentistry the complete medical record of **PATIENT:**_____, **DOB:**_____, including any records that may contain protected health information related to HIV/AIDS, alcohol and drug abuse, and/or mental health.

I understand that the disclosure of records authorized herein is required for official use by the West Virginia Board of Dentistry, its agents and representatives, in the course of investigating possible violations of the laws of West Virginia and any administrative proceedings related thereto. My healthcare records are not public records and are requested solely for such purposes.

I further authorize the West Virginia Board of Dentistry to use, disclose, or re-disclose any such records obtained pursuant to this release, without redaction of my personal identifiable information, for the purposes described above and to make copies thereof. I understand and hereby authorize that the West Virginia Board of Dentistry may provide copies of all documents and things received pursuant to this authorization to counsel of record and other qualified third parties, including expert witnesses, for use in administrative proceedings before the Board. Only individuals directly involved in such proceedings will have access to my healthcare records.

I understand that information used or disclosed under this authorization may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization by sending written notice of revocation to: West Virginia Board of Dentistry, c/o Executive Director, 1319 Robert C. Byrd Drive, PO Box 1447, Crab Orchard, WV 25827. I understand that my revocation will only be effective after the Board receives it, and that any disclosures made before my revocation will not be affected by my revocation.

A photo copy of this authorization shall be deemed as effective as an original.

Name: _____
Patient or Legal Guardian of Patient

Signature: _____ **Date:** _____

THIS AUTHORIZATION SHALL BE EFFECTIVE FOR
TWO YEARS FROM THE DATE OF SIGNING