



## South Dakota Board of Addiction and Prevention Professionals

P.O. Box 340, 1351 N. Harrison Ave., Pierre, SD 57501-0340

Ph: 605-224-1721 E-mail: [bapp@midwestsolutionssd.com](mailto:bapp@midwestsolutionssd.com)

Website: <https://dss.sd.gov/licensingboards/bapp/bapp.aspx>

### Complaint Form

Please **type** or **print legibly** and return to the above address. Form must be **SIGNED**.

PARTY MAKING THE COMPLAINT:			
NAME		PHONE NUMBER	
ADDRESS		HOME	
CITY	STATE	ZIP	CELL NUMBER
HAVE YOU FILED ANY PREVIOUS COMPLAINTS WITH THIS BOARD?		YES	NO

PARTY AGAINST WHOM COMPLAINT IS MADE:		
NAME		DAYTIME PHONE
ADDRESS		
CITY	STATE	ZIP
COUNSELOR LICENSE NUMBER (if known)		

DETAILS OF COMPLAINT			
<p>1. NATURE OF YOUR COMPLAINT (Check all that apply)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> <ul style="list-style-type: none"> <li>Standard of Care</li> <li>Dual Relationship</li> <li>Breach of confidentiality</li> <li>Unlicensed practice</li> <li>Violation of professional standards</li> </ul> </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> <ul style="list-style-type: none"> <li>Practice beyond scope (<i>training, education, expertise</i>)</li> <li>Other. Please describe:</li> <li>_____</li> <li>_____</li> </ul> </td> </tr> </table>		<ul style="list-style-type: none"> <li>Standard of Care</li> <li>Dual Relationship</li> <li>Breach of confidentiality</li> <li>Unlicensed practice</li> <li>Violation of professional standards</li> </ul>	<ul style="list-style-type: none"> <li>Practice beyond scope (<i>training, education, expertise</i>)</li> <li>Other. Please describe:</li> <li>_____</li> <li>_____</li> </ul>
<ul style="list-style-type: none"> <li>Standard of Care</li> <li>Dual Relationship</li> <li>Breach of confidentiality</li> <li>Unlicensed practice</li> <li>Violation of professional standards</li> </ul>	<ul style="list-style-type: none"> <li>Practice beyond scope (<i>training, education, expertise</i>)</li> <li>Other. Please describe:</li> <li>_____</li> <li>_____</li> </ul>		
<p>2. HAVE YOU COMMUNICATED YOUR CONCERN TO THE PERSON OR OFFICE? <span style="float: right;"><b>YES</b> <b>NO</b></span> IF YES, ON WHAT DATE AND BY WHAT MEANS:</p>			
<p>3. DID THE PERSON OR THE OFFICE RESPOND? <span style="float: right;"><b>YES</b> <b>NO</b></span> IF YES, WHAT WAS SAID OR DONE?</p>			
<p>4. WILL YOU, AS THE COMPLAINANT, WILLINGLY TESTIFY IF A HEARING SHOULD BE CALLED BY THE SD BOARD OF ADDICTION AND PREVENTION PROFESSIONALS FOR THE PURPOSE OF PRESSING CHARGES ARISING FROM THIS COMPLAINT? <span style="float: right;"><b>YES</b> <b>NO</b></span></p>			

**STATE YOUR COMPLAINT:** (In the space below, please state clearly and specifically, all charges made against the party named above. Be it known, your complaint will be sent to the practitioner named above for his/her response. **If more space is needed, please attach additional sheets of paper.**

I verify that I have read the foregoing complaint and the same is true to the best of my knowledge, information and belief. I hereby waive any right of confidentiality or privilege under state law, federal law or the law of the land. I specifically acknowledge and understand that the Board may disclose confidential and privileged information as the Board or its staff deem necessary to investigate and process this complaint. I understand that a copy of this complaint will be provided to the licensee.

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date

**South Dakota Department of Social Services  
SD Board of Addiction and Prevention Professionals**

**CONFIDENTIALITY WAIVER & RELEASE OF INFORMATION**

I, the undersigned, hereby authorize and direct you to release to the South Dakota Board of Addiction and Prevention Professionals all health records and information, (including but not limited to: intake information, informed consent documents, notes, summaries, billing records, etc.) in your possession and control regarding  
[NAME OF CLIENT] as may be required by the Board or its agent(s).

I understand that release of said information may include information regarding my diagnosis and treatment. I further understand that I may revoke this authorization at any time by notifying the Board in writing. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure as necessary to resolve any complaint pending before the Board. I acknowledge that my refusal to sign this waiver and release may result in the Board, and/or its agents, determining that no review of any complaint filed with the Board shall be undertaken. This waiver and release shall be effective until written revocation of the same is received by the Board.

A copy of my signature on this release shall be authorization and direction to release such records and information as is appropriate for the review of any complaint filed with the Board. If the complaint involves a minor, this release must be signed by the minor's parent or legal guardian, and authorizes the release of the minor's mental health records to the Board and its agent(s). A copy of this waiver and release carries the same weight and authority as the original.

I also hereby consent to the release of my identity and records to agents of the Board involved in the investigation, other state licensing boards, and law enforcement agencies as necessary.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

(Check one)     Client     Parent/Guardian