South Dakota Department of Social Services

South Dakota Board of Addiction and Prevention Professionals
PO Box 340
Pierre, SD 57501
Phone: 605.224.1721
Web: dss.sd.gov
Email: bapp@midwestsolutionssd.com

COMPLAINT FORM

PARTY MAKING THE COMPLAINT

Print Your Name _____

Address _____

Phone Number_____

PARTY AGAINST WHOM COMPLAINT IS MADE

Print Name _____

Address _____

Certified Addiction or Licensed Addiction Counselor License Number (if known) _____

NATURE OF COMPLAINT (On a separate sheet of paper, please state clearly and specifically, all charges made against the party named above. Be it known, your complaint will be sent to the counselor named above for his/her response.)

WILLINGNESS TO TESTIFY Will you, as the Complainant, willingly testify if a hearing should be called by the Board of Addiction and Prevention Professionals for the purpose of pressing charges arising from this complaint? ____ Yes/No

I hereby certify that the attached stated charges are true and correct to the best of my knowledge. Further, I waive confidentiality by submitting the following Confidentiality Waiver & Release of Information, and authorize disclosure of information as the Board or its staff deem necessary to review or pursue this complaint.

Signed*_____

*Before me personally appeared _____ whose signature appears above, and made oath and says that he/she is the identical person making this complaint and that all the foregoing statements are true and correct.

My commission expires_____

(seal) Notary Public Signature _____

South Dakota 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