

**OREGON BOARD OF LICENSED PROFESSIONAL COUNSELORS & THERAPISTS
CONFIDENTIAL COMPLAINT FORM**

3218 Pringle Rd SE, Suite 120 - Salem, Oregon 97302-6312
Fax: 503-470-6266 Email: LPCT.Board@state.or.us

Please complete BOTH pages of this form, including the release of information, if applicable. Keep a copy for yourself, and return the original to the Board's office via one of the above methods.

I want to file a complaint against the following Counselor or Therapist:

Name of counselor / therapist	Title
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Name of business	Telephone
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Address and e-mail	City	State	Zip Code
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Type of complaint: (Please mark those applicable)

- Unlicensed individual indicating that he/she is licensed as a professional counselor and/or therapist.
- Violation of law or rules regulating licensed counselors/therapists, relating to:
 - Ethical standards
 - Self-report / Report of another licensed professional
 - Attempting to/obtaining licensure by bribery or fraudulent misrepresentation
 - Inability to perform counseling or therapy by reason of mental illness, physical illness, drug addiction or alcohol abuse
 - Being grossly negligent in the practice
 - Practicing outside the scope of competence for which the licensee has been trained
- Incompetence

Please review Division 100 of the Board's code of ethics and explain your complaint thoroughly. Attach supporting documentation including names, addresses, telephone numbers and witnesses.

Print your name and email address	Telephone
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Address	City	State	Zip code
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Signature	Date
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**STATE OF OREGON
BOARD OF LICENSED PROFESSIONAL COUNSELORS & THERAPISTS
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Name of Client

Date of Birth

Social Security (Optional)

I hereby authorize: _____

(Name of Counselor/Therapist/Physician, or Mental Health Agency)

(Address)

to release information specified below from the case records of person listed above to the Oregon Board of Licensed Professional Counselors and Therapists or its authorized representative.

Dates of records to be released:

Content of material or information to be disclosed:

or check boxes that apply:

Social, medical, mental health or psychological reports/records

Medication(s) used in treatment

Treatment goals and results

*Information about drug and/or alcohol abuse

*If information is being disclosed from records whose confidentiality is being protected by federal regulation (42 CFR, part 2), information will be so noted which prohibits the Board from making further disclosure of it without specific written consent of client or as otherwise permitted by such regulation.

Purpose of disclosure: At the request of the OBLPCT in an investigation into the professional conduct and/or competence of the following counselor/therapist:

Date: _____

Signature: _____

(Client or Guardian)

Return this form to:

3218 Pringle Rd SE #120

Salem, Oregon 97302-6312

(Print)

(Address)