

MINNESOTA BOARD OF OPTOMETRY

335 Randolph Avenue, Suite 210, St. Paul, MN 55102
(651) 201-2762

While we do not desire to unduly complicate the submission of your complaint, it is extremely important that we have it in writing from you, signed and dated, so that it can be properly evaluated. To facilitate this, you will find at this site a complaint registration form and health record waiver form. In order for this office to verify the complaint, please state in detail on the complaint registration form all facts, which relate to the complaint. Please include any relevant names, dates, times and places and list of documents or records that you have or know about which bear on this matter. It would be helpful if you can supply a copy of such documents or records, or the originals, which, if you request, we will photocopy, and return to you.

You will note that there is a place to have your statement of complaint notarized. Should your complaint be verified, and it is determined to proceed with a disciplinary hearing, Minnesota law prohibits the scheduling of such a hearing without having a notarized complaint on file.

If you are alleging that the licensee improperly treated you in some way, access to your health records maintained by the licensee or other health professionals may be important in order that the Board may properly and thoroughly evaluate and investigate your complaint and, if necessary, submit the records in any potential legal proceeding. For this reason, the health record waiver authorization form must be submitted. It is not legally necessary for you to sign the enclosed waiver form. Your complaint will still be evaluated whether or not you sign the waiver and, if the complaint is verified, a determination will be made whether or not the matter is one, which under law justifies the Board to initiate a disciplinary action against the licensee. Should you sign the form, however, you would permit the licensee or other health professionals to furnish information of your condition to the Board, its authorized agents and agents of the Attorney General's Office, which represents the Board. In addition, the licensee or other health professionals would be permitted to testify concerning their findings or treatment and relieved of liability for so releasing the information or testifying. This information is furnished pursuant to the Minnesota Government Data Practices Act.

Finally, may I again remind you to sign and date the complaint registration form. Please return it and the waiver to the address at the top of this letter. Upon receipt of the complaint, it will be evaluated. You will be informed of the developments.

Sincerely,

Britt Heglund
Executive Director

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HEALTH RECORDS WAIVER FORM

TO: ANY DOCTOR, HOSPITAL, CLINIC, OR OTHER INSTITUTION

Having been informed of my rights under the Minnesota Government Data Practices Act, I authorize you to furnish a copy of my records in your possession to, or allow those records to be inspected and/or copied by the Minnesota Board of Optometry, its agents, and agents of the Attorney General's office representing the Board. I further authorize you to testify without limitation as to any and all of your findings and/or treatment referred to in said records. I release you, the Minnesota Board of Optometry, its agents, and the agents of the Attorney General's office representing the Board from liability for so releasing said records or so testifying and I waive any privileges afforded me by the law relating to the disclosure or introduction into evidence of health information.

I also agree to permit and hereby authorize the Board to use my name and/or my records in any legal proceeding arising out of this matter.

Name _____

Address _____

Date _____