



**Ohio Chemical Dependency Professionals Board**  
77 South High Street, 16<sup>th</sup> Floor  
Columbus, OH 43215  
614-387-1110 phone (614) 387-1109 fax  
[www.ocdp.ohio.gov](http://www.ocdp.ohio.gov) info@ocdp.ohio.gov

## ETHICS GRIEVANCE FORM

This form is to be used to file an ethics complaint against a Chemical Dependency Counselor (CDCA, LCDC II, LCDC III or LICDC) or a Prevention Professional (RA, OCPSA, OCPS or OCPC). Including your name, address and phone number is optional, however, it may be necessary for our Board to contact someone if we need information to further proceed on grievance investigation.

**Please note: The OCDP Board may not be able to investigate your grievance if insufficient information is provided.**

### PERSON FILING THE GRIEVANCE:

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Cell phone: (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

### GRIEVANCE FILED AGAINST:

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

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Home Address (if known): \_\_\_\_\_

License Type and License #: \_\_\_\_\_

Have you voiced your complaint to the employer or facility and/or followed their internal grievance process?

Yes  No

If yes, what was the outcome?

\_\_\_\_\_  
\_\_\_\_\_

Do you want to remain anonymous?

Yes  No

If you name a current or past client in this grievance you must include a signed release of information from the client. Is there a signed release of information included?

Yes  No

**NOTICE:** The respondent will receive a copy of the grievance.

Please describe the conduct or behavior which is the basis for your grievance **on a separate sheet**. Please include the dates the conduct occurred and any other pertinent facts.

**\*\*Please provide as much detail as possible.**

Which Code of Ethics has the Licensee/Credential holder violated? <http://codes.ohio.gov/oac/4758-8>

---

**PLEASE NOTE:**

**Do NOT include past or present client names without forwarding a signed consent from the client.**

**The OCDP Board may not be able to investigate your grievance if insufficient information is provided.**

**Important: Attach a separate sheet describing conduct or behavior which is the basis for your grievance**

Please list other persons who might have information pertinent to your grievance:

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

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

By signing this grievance, I assert that all information is true to the best of my knowledge.

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

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

## Authorization for Release of Information

1. Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

2. I authorize \_\_\_\_\_ to release information to:

The Ohio Chemical Dependency Professionals Board  
77 S. High Street – Floor 16  
Columbus, OH 43215  
(614) 387-1110

3. Date(s) of service (Month, Day & Year to the best of your knowledge): \_\_\_\_\_

4. **Specific information to be released:**

History & Physical Exam  
Psychiatric/mental health evaluation  
Treatment Plan  
Progress Reports  
Discharge Plan  
Other (Specify): \_\_\_\_\_

5. Reason for disclosure: \_\_\_\_\_

6. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked) expires one year from the date provided below.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Client/Legal Guardian/Parent)

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This information has been disclosed to you from records protected by Federal Confidentiality rule. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Your healthcare or payment for care will not be affected by whether you sign this authorization.

A photocopy or facsimile of this authorization will have the same authority as the original.

### Revocation of Release of Information

I hereby withdraw my consent for this release of information:

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