Kentucky Board of Speech-Language Pathology and Audiology
Public Protection Cabinet – Department of Professional Licensing
P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.8801 | Fax: (502) 564.4818 | SLP.ky.gov | slpa@ky.gov

COMPLAINT FORM , INFORMATION SHEET, AND AUTHORIZATION FOR RELEASE OF MEDICAL AND CLIENT RECORDS

WHAT ARE YOUR RIGHTS? You have a right to expect a professional standard of conduct from a person licensed by the Kentucky Board of Speech-Language Pathology and Audiology (the "Board"). If you believe a licensed Audiologist, Speech-Language Pathologist, Speech-Language Pathology Assistant, or a Temporary or Interim licensee, has violated Kentucky statutes or regulations, you may send a written complaint to the Board. As the body responsible for regulating the profession and protecting the public in matters related to speech-language pathology and audiology, the Board will review your complaint and take appropriate action.

HOW DOES THE COMPLAINT PROCESS WORK? Complaints that have been received in writing at the Board office will be acknowledged by letter. A copy of the complaint will be forwarded to the individual named in the complaint who will be given twenty (20) days to respond. A copy of any response will be sent to you, and you will have seven (7) days from receipt of the response to submit a written reply. The complaint, response, and any reply will then be reviewed by the Board at the next scheduled regular meeting. If no law appears to have been broken, you will receive notification from the Board. If the Board believes a law may have been broken, an investigation will take place. If the Board files formal charges against a licensee because of the investigation, an administrative hearing may be held. This formal hearing involves lawyers, a court reporter, a hearing officer and witnesses. If the Board finds that the licensee has not met the prescribed standard of conduct, it has the authority to impose penalties ranging from suspension or loss of a license to a reprimand. An informal settlement may be reached by agreement between the Board and the licensee.

WHAT MIGHT I EXPECT FROM FILING A COMPLAINT? The complaint process is a detailed and careful one, and you should expect some delay. In every case the licensee will be informed that a complaint has been filed, the name of the complainant, and the disposition of the complaint. Not every complaint result in disciplinary action by the Board if there is not sufficient evidence the individual has violated the laws governing this profession. If charges are filed, a hearing may be held similar to a court trial, and it is open to the public. You may be subpoenaed as a witness to provide testimony regarding the case. In this event Board counsel will assist you in preparing for the hearing. If the Board orders a specific sanction, the individual has the right to appeal, and a final decision may be delayed in the courts. While you may have an opinion regarding the process and outcome of processing your complaint, please remember that the decision to dismiss or settle a case or propose disciplinary measures is solely the decision of the Board and may be subject to review by the courts. If the Board files formal charges or takes formal action against a licensee, most portions of the investigative file will become "public record" which can be viewed by any individual who requests, in writing, to do so. The record may include your written complaint, transcripts, or reports of interviews, letters, and other reports. All testimony and evidence admitted in a formal hearing have the status of public record as well. Patient records obtained in the process of investigation usually can be protected from disclosure as public records. Throughout the various stages of the complaint process, you will be kept informed. You will also be advised of the outcome.

HOW DO I MAKE A COMPLAINT? You should complete the complaint form that accompanies this information sheet. Make sure you give all pertinent information. Please sign the complaint form so that the Board may look further into your concerns. If your complaint refers to treatment of a specific client or patient, the client or patient must sign the "Authorization for the Use and Disclosure of Health Information" form as well. Complaints and release forms on the following pages should be mailed to:

KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY
PO BOX 1360
FRANKFORT, KY 40602

DPL-SLPA-11
Rev. July 2026
KRS 334A.180, 334A.055
and 201 KAR 17:070

COMPLAINT FORM

COMPLAINANT INFORMATION

Name: _____

Address: _____

Phone: _____ Email Address: _____

☐ **AUDIOLOGIST**
☐ **INTERIM SPEECH-LANGUAGE PATHOLOGIST**
☐ **INTERIM SPEECH-LANGUAGE PATHOLOGY ASSISTANT**
☐ **SPEECH-LANGUAGE PATHOLOGIST**
☐ **SPEECH-LANGUAGE PATHOLOGY ASSISTANT**

Name: _____

Business Name: _____

Address: _____

Phone: _____ Email Address: _____

PATIENT INFORMATION

Name: _____

Address: _____

Telephone: _____ Email Address: _____

Relationship to person filing complaint: _____

Name: _____ Phone: _____ Type of Information: _____

Name: _____ Phone: _____ Type of Information: _____

Name: _____ Phone: _____ Type of Information: _____

Name: _____ Phone: _____ Type of Information: _____

Send to: **KENTUCKY BOARD OF SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY**
PO BOX 1360
FRANKFORT KY 40602-1360

SUMMARY OF COMPLAINT

(Please be as specific as possible regarding names, dates, locations, and actions which you believe to be improper, unethical or unprofessional.) Please attach copies of any documents or records pertinent to your complaint.

Name: _____ Date: _____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Full Legal Name: _____

Address: _____

Date of Birth: _____ Social Security #: _____

Medical Record #_____ Phone: _____

I, the undersigned, hereby authorize_____ to use or disclose my health information, as described below, to the Kentucky Board of Speech-Language Pathology & Audiology or any authorized agent or investigator of the Board. I authorize **the Board** to obtain my health information, as described below, from (name or names of health care provider): _____. The information to be used or disclosed includes the following specified information: All Medical Records maintained by the health care provider(s) named above during approximate time period from_____ to _____ including information related to my identity, diagnosis, prognosis and/or treatment, any and all medical records, billing information, and medical reports from the above-named Licensee and other health care providers.

I understand that the above records may be used by the Board in the investigation and possible disciplinary prosecution under KRS Chapter 334A against the licensee. A photocopy of this authorization shall be deemed effective as an original. This release is being executed in the context of health oversight activities and administrative proceedings by the Kentucky Board of Speech-Language Pathology & Audiology. As such, this disclosure is permitted under 45 C.F.R. Section 164.512(a), (d), and (e), the regulations implementing the Health Insurance Portability and Accountability Act ("HIPPAA"). The Board will make reasonable efforts to protect the confidentiality of these records under KRS Chapter 61 and Chapter KRS 13B, or other applicable law.

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements for alcohol and drug abuse patient records and the Public Health Service Act. Such information may not be used to criminally investigate or prosecute any alcohol or drug patient. Further, state law prohibits a recipient from making any further disclosure of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

This authorization will expire upon the occurrence of the following event or condition: _____

_____

If no event or condition is listed, it will expire in one (1) year. I understand that I have the right to revoke this Authorization at any time, and to do so, I must present a written revocation to the health care provider and the Board. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I should keep a copy of this Authorization form, after signing it.

Signature of Patient/Authorized Representative (include relationship): _____

_____

Signature of Witness: _____ Date: _____