Mississippi Board of Psychology
P.O. Box 20 Jackson, MS 39205

REQUEST FOR INVESTIGATION

Instructions: Please fill out this form completely. Type or print in black ink. Give full details of the investigation request. Information on this form will be used only for the purpose of investigation. This form must be notarized.
Note: The Board only has the authority to investigate its licensees or unlicensed persons claiming to be psychologists or to provide psychological services. The Board licenses: Psychologists, Provisionally Licensed Psychologists and Temporarily Licensed Psychologists.

BOARD USE ONLY

Date Received: _____

Case Number: _____

License Number: _____

PERSON REQUESTING INVESTIGATION

Your Name: Home Phone: ( )

Your Street Address or P.O. Box: Business Phone: ( )

City: State: Zip Code:

PSYCHOLOGIST YOU REQUEST BE INVESTIGATED

Psychologist's Name: Business Phone: ( )

Group/Hospital/Clinic:

Address:

City: State: Zip Code:

UNLICENSED PERSON CLAIMING TO PROVIDE PSYCHOLOGICAL SERVICES

Person's Name: Business Phone: ( )

Address: Name of Practice:

City: State: Zip Code:

DETAILS OF YOUR COMPLAINT FOR INVESTIGATION BY THE BOARD

Please summarize the details of your complaint as clearly and completely as possible. Also, please describe any supporting documents in your possession that pertain to this specific complaint. You may use additional sheets of paper if necessary.

Continue the details on the next page of this form

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Please enclose any additional documentation that will support your allegations. If court documents, including transcripts, reports, deposition, etc. are the basis of your complaint, these must be provided to the Board before an investigation may proceed.

I understand that by filing this request for investigation, I am giving the Mississippi Board of Psychology permission to inquire into information that is normally held confidential between myself and the licensee, I have filled out the release of information form on page 3, and

Authorizing the Mississippi Board of Psychology to investigate and resolve this matter in accordance with the Board's Rules and Regulations, and

I certify that all the information I have given herein is true, correct and compete to the best of my knowledge.

Signature of Complainant: _____ Date: _____

NOTARIZATION IS REQUIRED:

STATE OF _____

COUNTY OF _____

Before me, a notary public, on the day personally appeared _____ known to me to be the person whose name is subscribed to the foregoing document and, being by me duly sworn, declared that the statements therein contained are true and correct. Given under my hand and seal of office this _____ day of _____ A.D., 20_____.

Notary Public Signature:

Notary Public

Printed or Typed Name:

My Commission Expires: _____

COMPLETE THE AUTHORIZATION FOR RELEASE OF INFORMATION FORM ON PAGE 3 OF THIS FORM

Mississippi Board of Psychology
P.O. Box 20 Jackson, MS 39205

AUTHORIZATION FOR RELEASE OF INFORMATION AND ANY PSYCHOLOGICAL, MEDICAL, ALCOHOL OR DRUG ABUSE, OR LEGAL RECORDS WHICH MAY PERTAIN TO MY REQUEST FOR INVESTIGATION

Your name (print or type using black ink): _____
Address: _____
City, State, ZIP: _____
Phone: ( ) _____ Date: _____

I, the undersigned, hereby authorize the following to disclose ALL psychological, psychiatric, medical, substance-abuse, and legal information or records concerning:

_____
_____
_____
_____

To: The Mississippi Board of Psychology
P.O. Box 20
Jackson, MS 39205
Attn: Request for Investigation

Records of (specify individual, clinic, hospital, etc. and give address):

_____
_____
_____

And release the above individual/institution from legal responsibility or liability for the release of my records or information.

The disclosure of records authorized herein is required for official use, including investigation of possible proceedings regarding any violations of the laws of the State of Mississippi.

This authorization shall remain valid until the Mississippi Board of Psychology completes its investigation and proceedings arising out of the investigation.

I understand that I have a right to receive a copy of this authorization by me. A copy of the authorization shall be as valid as the original.

_____ _____
Signature of Complainant and/or Patient Date

_____ _____ _____
Representative Signature Relationship Date

_____ _____
Witness Signature Date