Mississippi Autism Board

Request for Investigation Form

Requestor Information		
Name:		
Street Address:		
City:		State:
Zip Code:		
Phone Number:		Cell Number:
Email Address:		

Behavior Analyst or Assistant Behavior Analyst To Be Investigated		
Name:		
Organization Name:		
Street Address:		
City:		State:
Zip Code:		
Work Phone Number:		
Email Address:		

Unlicensed Person Claiming to Provide Services as a Behavior Analyst or Assistant Behavior Analyst		
Name:		
Organization Name:		
Street Address:		
City:		State:
Zip Code:		
Work Phone Number:		
Email Address:		

Compliant Details and Information for Investigation by MAB

Please summarize the details and information of your compliant as clearly and concisely as possible. Additionally, please describe any other information or documentation you possess or have knowledge of that is pertinent to your complaint. You may attach additional documents or information if necessary, including but not limited to, transcripts, reports, deposition(s), etc.

_____ I understand that by filling this request for investigations, I am giving the Mississippi Autism Board 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 4, and

_____ I hereby authorize the Mississippi Autism Board to investigate and resolve this matter in accordance with its Rules and Regulations, and

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

Signature of Complainant: _____ Date: _____

NOTARIZATION FORM

SIGNATURE OF COMPLAINANT: _____

DATE: _____

SWORN BEFORE ME THIS DAY _____ **OF** _____ **A.D. 20** _____

SIGNATURE OF NOTARY PUBLIC _____

PRINTED OR TYPED NAME: _____

MY COMMISSION EXPIRES: _____

SEAL

Authorization for Release of Information

Name:		
Street Address:		
City:		State:
Zip Code:		

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

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

Records of (specify individual, clinic, hospital, organization, etc. and provide 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 Autism Board 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: _____ Date:_____

Representative Signature: _____ Relationship: _____ Date: _____

Witness Signature: _____ Date:_____