Before the Nevada State Board of
Marriage and Family Therapist Examiners

_____,
Complainant,

vs. COMPLAINT

_____,
Respondent,

COMES NOW _____, and files

This complaint against _____ and alleges that the above-named Respondent has violated certain provisions of Chapter 641A of the Nevada Revised Statutes by:

(Here set out a complete statement of facts which constitute acts and omissions in violation of Chapter 641A. Please be sure that the statement is sufficiently particular to enable the respondent to understand the complaint, that all dates on which the acts are alleged to have occurred are specified, and all applicable laws, rules and regulations and orders of the board are cited.) YOU ARE TO USE THE SPECIFIC NRS AND/OR NAC CHAPTER NUMBERS AND ITEM (Paragraph) NUMBERS WHICH APPLY TO EACH ITEM OF THE COMPLAINT. (Use additional pages if necessary)

WHEREFORE, _____ (Name of Complainant) prays the Nevada State Board of Marriage and Family Therapist Examiners commence administrative proceedings against the above-named Respondent to take appropriate disciplinary action.

STATE OF NEVADA)
) SS:
COUNTY OF _____)

_____, being first duly sworn, deposes and says:

That (he or she) has filed this _____ (complaint, answer or application); that (he or she) has read the foregoing and knows the contents thereof; that the contents are true of (his or her) own knowledge, except for those matters therein stated upon information and belief, and as to those matters, (he or she) believes them to be true. Subscribed and sworn to me this

_____ day of _____, 20__

_____
(Signature of person filling complaint)

(Notary Public in and for said County and State)

_____
(Address)

_____ ____-_____
(City, State, Zip) (Phone)

CONSENT FOR THE RELEASE
OF CONFIDENTAL INFORMATION

I, _____, authorize _____
(Name of patient)

_____
(Name or general designation of program making disclosure)

to disclose to the Nevada Board of Marriage and Family Therapist Examiners (P.O. Box 370130 Las Vegas, NV 89137-0130) the following information:

_____
(Nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized herein is to:

_____
(Purpose of disclosure, as specific as possible)

_____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed with out my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

_____

Dated: _____

_____
Signature of participant

_____
Signature of parent,
Guardian or authorized
Representative when required

STATE OF NEVADA BOARD OF EXAMINERS FOR MARRIAGE & FAMILY THERAPISTS AND CLINICAL PROFESSIONAL COUNSELORS

7324 West Cheyenne Ave., Suite #9
Las Vegas, Nevada 89129
(702) 486-7388

Release of Treatment Records & Information

I _____, Patient, or as Legal Representative/Guardian for _____ ("Patient"), hereby authorize the Marriage and Family Therapist/Intern, Clinical Professional Counselor/Intern, or other Healthcare Professional, Hospital, Clinic or other medical related facility (referred to collectively herein as "health providers") identified below to release Patient information and treatment records to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors ("Board") at the above address.

_____

(Print name of individual or facility from whom or from which records are being requested.)

1. I hereby release all of the above named health providers from all liability and all claims of any nature arising out of disclosure of information contained in my treatment records, or related to Patient's treatment, as may be requested by the Board for the investigation of a complaint filed with the Board.

It is understood that this release will be used in the following ways:

2. The information requested/received will be used only for the investigation of a complaint filed with the Board relating to Patient's treatment, pursuant to the authorized responsibilities of, the Board.

3. All treatment information is authorized to be released including, but limited to, Patient's history, mental or physical condition(s), diagnosis, prognosis, treatment, laboratory reports, testing results, communications, and the health professional(s)'s notes.

4. This release shall be valid for one year from date of signing unless revoked in writing by the Patient.

5. A copy of this release is as valid as the original.

Date: _____, 201__.

_____

Signature of Patient

Date: _____, 201__.

_____

Signature of Patient's Parent Or Guardian (If required.)

Date: _____, 201__.

_____

Signature of Witness