

*Hilltop Counseling Services*  
1045 Elm Street  
Bowling Green, KY 42101  
270-843-1804  
Fax: 270-843-0154

AUTHORIZATION FOR RELEASE/ EXCHANGE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

1. The undersigned hereby authorizes: Hilltop Counseling Services: 1045 Elm Street Bowling Green, KY 42101 to exchange information from the medical (health) record of:

Name	S.S. Number
Birthdate	Dates of treatment/service

- 2. Information to be exchanged with: County of Conviction
  
- 3. Specific description of information to be released (how much, what kind): Enrollment of DUI Program, Completion/Non-compliance of Program, Any Reports Requested by Individual or Judge.
  
- 4. Purpose of release: Compliance With Court Order, License Reinstatement.
  
- 5. I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.
  
- 6. I understand that I may see and copy the information described on this form if I ask for it, and that I may request a copy of this form after I sign it.
  
- 7. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on my actions they took before they received this revocation.
  
- 8. It is understood that this authorization for release is subject to my revocation at any time, and that unless another date is specified, this release will expire sixty (60) days after is is signed. **TIME, EVENT OR CONDITION LIMITING RELEASE:** \_\_\_\_\_

This information has been disclosed to you from records whose confidentiality is protected. Regulations prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Signature of Client	Printed Name of Client	Date
Signature of Witness	HCS Therapist/ Counselor	Date