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: the Kentucky Division of Substance Abuse, Frankfort, KY.

3. Specific description of information to be released (how much, what kind): Full health record to include: treatment information, administrative information and vital statistics of individual.

4. Purpose of release: All DUI agencies are under the authority of the Kentucky Division of Substance Abuse and are required to undergo annual reviews to determine that the standard level of care is being met. This release allows your records to be part of that review.

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

_____ HCS/ Therapist/Counselor _____
Signature of Witness Date