The Next Step Counseling Services, LLC
Authorization to Release Information

I, _____
Client Name Social Security Number Date of Birth

hereby authorize: **The Next Step Counseling Services, LLC**
1106 Tunnel Hill Road, Suite 100
Elizabethtown, KY 42701
Phone (270) 765-2335 /Fax (270) 765-2557

To obtain from _____ To release to _____

Name:_____Agency:_____

Address:_____

The following information: (nature of information is as limited as possible) Check each category that applies:

____ Attendance Report; _____Discharge Summary; _____Status of Recommended Services; _
____ Summary of Assessment/Evaluation Summary to include information regarding impressions of the Therapist in the areas of Substance Use, Domestic Violence, Mental Health and Learning Problems, to include recommendations and plan for services and to redisclose any collateral information collected during the assessment process;
____ Referral Information/Treatment Information to include Drug and Alcohol Abuse;
____ Referral Information/Medical Information from a Referring Physician
***Referring Physician Signature _____
____ Other _____

I understand that the purpose of this disclosure is for:

Referral _____ Monitor Progress _____ Coordination of Services _____Other: _____

PROHIBITION ON REDISCLOSURE: According to 45 CFR 164.508 c2Ciii health information may be redisclosed by the recipient. However, pursuant to **KRS 304.17A-555**, **Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure** mental health/chemical dependency info may not be used and/or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person to whom it pertains. Additionally, **Federal Regulations 42CFR, Part 2** prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have read this form and agree to the disclosure set forth above. I understand that this form is not required as a condition of my involvement with this agency. I will be given a copy of this form if I ask; and, I may inspect or obtain a copy of material to be disclosed if I ask. I understand that this authorization expires one year from date of signature or sooner. I understand that I can revoke this authorization at any time by signing the bottom of this form. However, The Next Step Counseling Services, LLC cannot be responsible for any release(s) of information prior to notification or when required by law.

Time Limitation of Release: This release expires: _____

_____ _____
Signature of Client Date

_____ _____
Witness Signature of Parent or Authorized Representative

******* I wish to revoke the above authorization. *******

_____ _____
Signature Date