KENTUCKY BOARD OF LICENSED PROFESSIONAL COUNSELORS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING
P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero Street 2SC32 Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.8803 | Fax: (502) 564.4818 | Website: lpc.ky.gov | Email: LPC@KY.GOV

Authorization for Release of Medical and Client Records

I, the undersigned, authorize the full release of any and all medical and psychological records, billing information, and medical and psychological reports from _____, a [ ] Licensed Professional Clinical Counselor [ ] Licensed Professional Counselor Associate and any medical records I provide as part of my complaint regarding the medical and psychological history, diagnosis, and treatment of _____ while a patient of said counselor to the Kentucky Board Licensed Professional Counselors or any authorized agent or investigator for the Board, that regard the referral, my medical history, diagnosis, and treatment,.

I understand my records may be used by the Board during an investigation and possible disciplinary prosecution under Kentucky Revised Statutes ("KRS") Chapter 335 and 201 KAR Chapter 36 against the licensee counselor. This involves health oversight activities and administrative proceedings of the Board and disclosure is permitted under 45 C.F.R. Section 164.512(a), (d), and (e), the regulations implementing the Health Insurance Portability Accountability Act (HIPAA). Information released in response to this authorization may be re-disclosed to other parties. I further understand that the Board will make reasonable efforts to protect the confidentiality of my records under KRS Chapter 61 and KRS Chapter 13B, or other applicable law.

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A photocopy of this authorization shall be deemed as an original.

This authorization shall be effective for one year from the date of signing. I may revoke this authorization at any time in writing, except to the extent information released has been released in reliance upon the authorization.

_____
Signature of patient, or parent/legal guardian of patient under 18 years old

_____
Date