KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS
PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING
P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero Street, Second Floor, Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.8814 | Fax: (502) 564.4818 | Website: adc.ky.gov | Email: adc@ky.gov

Complaint Form

Instructions:

1. Once you have completed the form, you must print the form and apply your handwritten signature. Complaint forms submitted without the appropriate signatures will be returned.'
2. The completed application may be submitted to the Kentucky Board of Certification of Alcohol and Drug Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by email to adc@ky.gov. If complaint is emailed, please make sure you reference "ADC Complaint" in the subject line.
3. Do not include patient identifying information in the complaint or attached documents.

Complainant:

Name:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Daytime Telephone: _____ Evening Telephone: _____

Email: _____

Name of Credential Holder your complaint is against:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Daytime Telephone: _____ Evening Telephone: _____

Have you filed this complaint with other agencies: Yes No
If yes, what other agency: _____

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201 KAR 35:061
CLEAN FORM
Filed: Nov. 10, 2026

Brief Summary of Complaint

Please print clearly or submit typed form. Please be specific as possible regarding names, dates, locations, and actions you believe to be improper, unethical or unprofessional. Include copies of any supporting documentation.

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By signing this complaint form, I hereby certify that the information is complete and true to the best of my knowledge.

Signature: _____ Date: _____

If your complaint concerns your treatment by this credential holder, please sign and enclose the "Client Agreement to Release Information" form.

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Authorization for Release of Medical and Client Records to the Kentucky Board of Alcohol and Drug Counselors

I, _____, the undersigned, do hereby authorize the full release of any and all medical and psychological records, billing information, and medical and psychological reports from _____ a credential holder, regarding the medical and psychological history, diagnosis, treatment, and/or recovery services of _____
while a client of the credential holder to the Kentucky Board of Alcohol and Drug Counselors or any authorized agent or investigator for the Board.

I understand my records may be used by the Board during an investigation and possible disciplinary prosecution under Kentucky Revised Statutes ("KRS") Chapter 309 and 201 KAR Chapter 35 against the credential. 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 and Accountability Act (HIPAA) and 42 C.F.R. Part II as applicable. 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.

A photocopy of this authorization shall be deemed 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 this authorization.

Signature: _____ Date: _____
Signature of client, or parent/legal guardian of client under the age of 18 years old