Kenny Wolford Counseling Services
220 NW Oregon Ave - Unit B
Bend, OR 97701

www.wolfordcounseling.com
Ph: 541.728.0636
Email: kenny@kennywolford.com

Active Enhancement LLC

Authorization For Release of Information [Please print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows **Kenny Wolford, MA,LPC,LMFT/Active Ehancement, LLC** to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Kenny Wolford/Active Enhancement, LLC. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Client Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)	**Date of Birth:** (Month/Day/Year)
Address: (including zip code)	**Telephone Number:** (including area code)

Social Security Number: (optional)

I authorize **Kenny Wolford, MA,LPC,LMFT/Active Enhancement, LLC** to release my protected health information as described below.

Recipient: (person or organization that will receive your information)

Person's Name or Organization:	**Telephone Number:** (including area code)
Address: (including zip code)	**Fax Number:** (if available)

Description of the Information to be Released: (what type of information will be released)

Psychotherapy Notes and pertinent psychotherapy information discussed in session.

Purpose of Release: _____

Examples: working with referrals such as physician, nutritionist, or other health practitioner.

***NOTE**: State law requires that you give specific permission to release the information below. Indicate your permission for release by intialing below.

Substance/Alcohol Abuse _____ (Initials) **Mental/Behavioral Health** _____ (Initials)

Expiration: (when this authorization will end)

This authorization will expire on ____/____/____(mm/dd/yyyy) **OR** on the occurrence of the following event:

_____

Examples: Until I revoke this authorization; Resolution of a specific issue

Approval: (You OR your legal guardian must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Signature:

By signing below, I authorize the use of my protected health information.

_____ _____

(Signature) **(Date)**