

Priscilla Klockner, M.A.

Professional Counselor Associate (OR R5148)

Dave Wenzel, PhD, LPC, Supervisor

2732 N.E. Broadway

Portland, Oregon 97232

503.327.4839

Client Request

Counselor Request

## Authorization to Release Protected Health Information

I, \_\_\_\_\_, hereby

Name of Client/Guardian

authorize Priscilla Klockner, MA, Professional Counselor Associate, 2732 NE Broadway, Portland, Oregon, 97232, 503- 327-4839, to mutually share with

\_\_\_\_\_  
Name, Title, Business Name, address, and Phone Number

any and all information pertaining to \_\_\_\_\_  
for the purpose of \_\_\_\_\_.

I have been informed and fully understand that this protected health information may be in written, oral, or report form.

I fully understand that by signing this form I hereby waive or give up my rights of confidentiality to those above-named and their supervisors. I further understand this communication may include, but not be limited to drug, alcohol, mental health, medical, legal, financial, insurance, or HIV-related information. Unauthorized redisclosure by recipients is a potential risk.

Except as to third party payers, this authorization does not include disclosure of future health care services received more than ninety (90) days from the date of last signature. This release/waiver may be revoked in writing at any time, except to the extent that disclosure has already been made in good faith reliance on this release. I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Client Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_