



6525 E Mainsgate Rd
 Wichita, KS 67226
 (316) 461-7923
 fax 260-7045

**AUTHORIZATION & REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION
 AND PRIVILEGED COMMUNICATION**

Client's Printed Name _____ Date of Birth: _____

I authorize my clinician: Please check one

<input type="checkbox"/> Brooke Miller, LMSW	<input type="checkbox"/> CJ Byler, LSCSW	<input type="checkbox"/> Chris Brunson, LPC	<input type="checkbox"/> Shelly Biays, LMFT	
<input type="checkbox"/> Jennifer Bruening, LCMFT	<input type="checkbox"/> Kari D. Vitosh, LCPC, NCC	<input type="checkbox"/> Kristin Kroeker, LCMFT, LPC	<input type="checkbox"/> Lou Smith, LMFT	
<input type="checkbox"/> James A. Smith, LCMFT	<input type="checkbox"/> Joyce Larson, LMFT	<input type="checkbox"/> Katy Fisher, LMFT	<input type="checkbox"/> Kirsten Palmer, Intern	
<input type="checkbox"/> Lori Osborn, LCMFT	<input type="checkbox"/> Mont Yourdon, LMFT			

(Please check all that apply)

- To exchange information with: Name: _____
 - To disclose information to: Address: _____
 - To obtain information from: City: _____ St: _____ Zip: _____
- Telephone: _____
 E-Mail: _____
 Fax: _____

Initial appropriate blanks and circle which one applies:

- ____ Admission summary, discharge summary, psychological testing report, list of medications.
- ____ School records (school progress notes, school intake evaluation, grades, attendance, IEP)
- ____ Psychological consultation report
- ____ Evaluation summary: Alcohol/DUI, Chemical Dependency, Sex Offender
- ____ Therapy notes including Treatment Plan (last 6 months)
- ____ Medical History: Medication checks, Lab reports (last 6 months)
- ____ Summary report of services received
- ____ Consultation and/or verbal communication between the above named parties
- ____ Other: _____

Expiration date: _____ (one year from date signed if not otherwise specified - effective for one year maximum).

I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to revoke the authorization, except to the extent action has been taken or it has been relied on, by putting my revocation in writing and delivering it to the clinician identified above.

I issue this authorization with knowledge of the contents of the material and communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-named clinician from any liability relevant to the release of confidential information or privileged communication.

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

Clinician Signature _____ Date _____