HERITAGE
FAMILY COUNSELING SERVICES

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

AUTHORIZATION & REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION AND PRIVILEDGED COMMUNICATION

Client's Printed Name_____ **Date of Birth:** _____

I authorize my clinician: Please check one

☐ Brooke Miller, LMSW	☐ CJ Byler, LSCSW	☐ Chris Brunson, LPC	☐ Shelly Biays, LMFT	
☐ Jennifer Bruening, LCMFT	☐ Kari D. Vitosh, LCPC, NCC	☐ Kristin Kroeker, LCMFT, LPC		
☐ James A. Smith, LCMFT	☐ Steve Edwards, LSCSW	☐ Katy Fisher, LMFT	☐ Jennifer Logan Armstrong, LSCSW	
☐ Lori Osborn, LCMFT	☐ Mont Yourdon, LMFT		☐ Teresa McDonald, LSCSW	

(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, Chemicl 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 Revised: June 10, 2017