



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, LSCSW	<input type="checkbox"/> CJ Byler, LSCSW	<input type="checkbox"/> Chris Brunson, LPC	<input type="checkbox"/> Shelly Biays, LCMFT
<input type="checkbox"/> Jennifer Bruening, LCMFT	<input type="checkbox"/> Kari D. Vitosh, LCPC, NCC	<input type="checkbox"/> Kristin Kroeker, LCMFT, LPC	
<input type="checkbox"/> James A. Smith, LCMFT	<input type="checkbox"/> Steve Edwards, LSCSW	<input type="checkbox"/> Katy Fisher, LMFT	<input type="checkbox"/> Jennifer Logan Armstrong, LSCSW
<input type="checkbox"/> Teresa McDonald, LSCSW	<input type="checkbox"/> Mont Yourdon, LMFT	<input type="checkbox"/> Lori Osborn, LCMFT	<input type="checkbox"/> Lindsay Kachelmeier, TLMFT

**(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 \_\_\_\_\_