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, LSCSW	☐ CJ Byler, LSCSW	☐ Chris Brunson, LPC	☐ Shelly Biays, LCMFT	
☐ Jennifer Bruening, LCMFT	☐ Kari D. Vitosh, LCPC, NCC	☐ Kristin Kroeker, LCMFT, LPC		☐ Melissa Beck, LMFT
☐ James A. Smith, LCMFT	☐ Steve Edwards, LSCSW	☐ Katy Fisher, LMFT	☐ Jennifer Logan Armstrong, LSCSW	
☐ Teresa McDonald, LSCSW	☐ Mont Yourdon, LMFT	☐ Lori Osborn, LCMFT	☐ Lindsay Kachelmeier, 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, 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: Sept 10, 2017