6525 E Mainsgate Rd
Wichita, KS 67226
(316) 461-7923
Fax (316) 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**

| | | |
|---|---|---|
| ☐ Ashley Burns, LMFT | ☐ Brooklyn Jesseph, LMSW | ☐ Chelsea Carson, LMFT |
| ☐ Chris Brunson, LPC | ☐ CJ Byler, LSCSW | ☐ Darla Stevens, LMSW |
| ☐ Hannah Lambert, LPC | ☐ James Smith, LCMFT | ☐ Jennifer Bruening, LCMFT |
| ☐ Katrina McFarland, LMFT | ☐ Katy Fisher, LCMFT | ☐ Kelli Kennedy, LMSW |
| ☐ Lauren Walton, LMFT | ☐ Lori Osborn, LCMFT | ☐ Michele Meinhardt, LSCSW |
| ☐ Melissa Beck, LCMFT | ☐ Robert Bragg, LMFT | ☐ Shelly Ingram, LCMFT |
| ☐ Brooke Wiltshire, Intern | ☐ Clark Munger, Intern | ☐ Kevin Neuenswander, Intern |
| ☐ Wendy Easter, Intern | | |

**(Please check all that apply**)

☐ **To exchange information with:**

☐ **To obtain information from:**

☐ **To disclose information to:**

Name:____________________________________
Address:__________________________________
City:_________________State______Zip______
Telephone:________________________________
Email:____________________________________
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