



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)

- List of 15 clinicians with checkboxes: Melissa Beck, LCMFT; Kathi Bragg, BCLC, BHP; Robert Bragg, LCMFT; Chris Brunson, LCPC; Ashley Burns, LMFT; CJ Byler, LSCSW; Chelsea Carson, LMFT; Katy Fisher, LCMFT; Brooklyn Jesseph, LPC; Tiffany Kelderhouse, LCPC; Hannah Lambert, LPC; Katrina McFarland, LMFT; Michele Meinhardt, LSCSW; Lori Osborn, LCMFT; James Smith, LCMFT; Cheryl Tan, APRN; Paul Williams, LPC; Mikaela Wright, LPC; Gabrielle Entz, Intern; Kevin Neuenswander, Intern; Talisha Thompson, 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 _____
Clinician Signature _____ Date _____

Client/Guardian Signature _____ Date _____