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 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

<input type="checkbox"/> Ashley Burns, LMFT	<input type="checkbox"/> Brooklyn Jessep, LMSW	<input type="checkbox"/> Chelsea Carson, LMFT
<input type="checkbox"/> Chris Brunson, LPC	<input type="checkbox"/> CJ Byler, LSCSW	<input type="checkbox"/> Hannah Lambert, LPC
<input type="checkbox"/> James Smith, LCMFT	<input type="checkbox"/> Jennifer Bruening, LCMFT	<input type="checkbox"/> John Ormiston, LSCSW
<input type="checkbox"/> Katrina McFarland, LMFT	<input type="checkbox"/> Katy Fisher, LCMFT	<input type="checkbox"/> Kristin Kroeker, LCMFT, LPC
<input type="checkbox"/> Lauren Walton, LMFT	<input type="checkbox"/> Lori Osborn, LCMFT	<input type="checkbox"/> Michele Meinhardt, LSCSW
<input type="checkbox"/> Melissa Beck, LCMFT	<input type="checkbox"/> Robert Bragg, LMFT	<input type="checkbox"/> Shelly Biays, LCMFT
<input type="checkbox"/> Shelly Ingram, LCMFT	<input type="checkbox"/> Steve Edwards, LSCSW	<input type="checkbox"/> Zach Werhan, LPC
<input type="checkbox"/> Brooke Wiltshire, Intern	<input type="checkbox"/> Clark Munger, Intern	<input type="checkbox"/> Wendy Easter, Intern

(Please check all that apply)

<input type="checkbox"/> To exchange information with:	Name: _____
<input type="checkbox"/> To obtain information from:	Address: _____
<input type="checkbox"/> To disclose information to:	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