McKenzie & Associates
Counseling Services

110 S. Main St. Ste. 500
Wichita, KS 67202

316-351-7644 Phone
316-351-7689 Fax

Medical Records Release Form

I, _____ (Client or Legal Guardian printed name)
authorize McKenzie & Associates LLC, to release the following information:

_____ All Records **(Initial)**
_____ Diagnoses **(Initial)**
_____ Summary **(Initial)**
_____Billing Matters **(Initial)**
_____ Scheduling **(Initial)**
_____ Assessments **(Initial)**
_____ Progress Notes **(Initial)**
_____ Treatment Plans **(Initial)**

____ Other: _____ **(Initial)**

For: ☐ ALL dates of service
or ☐ the following dates of service: _____ to _____

You may release this health information to the following individual/agency:
Name: _____
Relationship to client: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number: _____
Email: _____

Per our policy, your request will be fulfilled within 10 business days of the date received.

This may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____ _____
Client Printed Name: **Client DOB:**

_____ _____
Client (or Legal Guardian) Signature: **Date: (Expires in 1 year)**