110 S Main St Ste. 500 316-351-7644 Phone
Wichita, KS 67202 316-351-7689 Fax

Authorization & Request of Confidential and Privileged Information

In accordance with my legal right to confidentiality and privileged communication relevant to the service that I have received, I authorize and request the disclosure of confidential information **from** McKenzie & Associates LLC clinician indicated above **to** the following individuals and agency. Additionally, I authorize and request release of confidential information **from** the following individuals or agency **to** McKenzie & Associates LLC.

Agency or Individual Name:			
Street:	City:	State:	Zip:
Phone:	Fax:		

Clients (or Guardians) Authorize Release:

Name:	Date of Birth:		
Street:	City:	State:	Zip:
Phone:			

Information that may be Released, please ***INITIAL*** all that apply:

___ Mental Health/ Physical Information

___ Diagnoses

___ Summary

___ Verbal Electronic Consultation

___ Assessments

___ Tx Plans

___ Demographic Information

By signing Below, the client is releasing and authorizing:

- A summary report of services received by both the indicated clinician, as well as the agency and individual noted above.
- Consultations and/or verbal communication between the above-named parties.
- Any and all records pertaining to services received by the indicated clinician as well the agency or individual noted above.

It is my understanding that this information will be used for consultation and treatment purposes. This consent expires one year from the date noted below unless revoked by me in writing at an earlier time. I issue this authorization with knowledge of the contents of the material or communication and understanding of consequences, and do so voluntarily and free from duress or undue influences. In accordance with Federal regulations (42 CFR Part 2) which prohibit any further disclosure of this information, except with specific written consent of the person to whom it pertains, re-disclosure of this information is prohibited. I hereby hold harmless the above-named practitioner from any liability relevant to the release of the confidential information or privileged communication. I agree to pay a reasonable fee for the preparation of the information released.

Printed Name of Client:	
Client (or Guardian) Signature:	Date (expires in 1 year):
Clinician Signature:	