Waiver of Physician Consult

I understand that my records are protected under the applicable state law governing confidentiality of client/therapist relationship and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke the consent at any time except to the extent that action has been taken in reliance on it.

In accordance with Kansas statute: *When a client has symptoms of a mental disorder, a licensed (marriage and family therapist/professional counselor/social worker) shall consult with the client's primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to the client's symptoms of a mental disorder. A client may request in writing that such a consultation be waived and such request be made part of the client's record.*

I,_____ DOB_____hereby authorize
(client's printed name)

Jennifer Harms, LCMFT, or Rachel Pearson, PhD, LCMFT, or Rosie Wuthrich, MS, LCMFT to act on the following:

Please initial one and note a Consent to Release Information must also be signed:

_____I agree that my therapist may consult with my physician.

Or

_____I do not agree that my therapist may consult with my physician.

Physician's name and office address:

_____

_____

_____

_____ _____ _____
(client's printed name) (client's signature) (date)

Or

_____ _____ _____
(guardian's printed name and relationship) (guardian's signature) (date)