**RELEASE OF INFORMATION TO PHYSICIAN**

**OR**

**WAIVER OF PHYSICIAN CONSULT**

I under stand 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 of 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 K.SA. 65-63O6, when a client has symptoms of a mental disorder, a Licensed Specialist Clinical Social Worker (LSCSW) 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 clients symptoms of a mental disorder, A client may request in writing that such consultation be waived and such request be made part of the client’s record.

I, hereby authorize Rebeca Sandoval, L.S.C.S.W. to act on the following:

**Please check one:**

\_\_\_\_\_\_\_\_\_\_\_ I consent to reciprocal release of information to my physician

\_\_\_\_\_\_\_\_\_\_\_\_I do NOT consent to reciprocal release of information to my physician and waive the

 physician consult.

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(Client’s Printed Name)

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(Client’s Signature or Parent/Guardian Signature) (Date)

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(Parent/Guardian’s printed name and relationship)

***Physician’s Name, Address, and Phone Number:***

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