Jennifer Reid, LSCSW

643 N. Armour St.
Wichita, Kansas 67206

Phone 316.304.3873
Fax 949.862.1619

I authorize Jennifer Reid, LSCSW to

____ Disclose information to ____ Request information from ____ Exchange information with

Name: ____

Address: ____

City:______________________ **State:**__________ **Zip:**______________________

Phone No:____________________ **Fax No:** ______________________

Information to be exchanged includes (please check and initial authorized information to be disclosed):

____ Admission Intake
____ Discharge Summary
____ Psychological Evaluation Report
____ Psychiatric Evaluation Report
____ Substance Abuse Report
____ Entire Record
____ Other:

____ Medical History, Lab Results
____ Diagnosis
____ Treatment Plan
____ Summary of Treatment
____ Progress Notes
____ Verbal or Written Progress Reports/Consultation

Purpose of Disclosure(s): _____ Comply with court order _____ Treatment of patient
_____ Response to referral source _____ Other: __________________
____

This consent can be canceled in writing at any time. When a patient/legal guardian revokes consent, Jennifer Reid, LSCSW is not liable for items sent after the consent is signed but before the cancellation of consent is received in our office. This consent is effective until 90 days after treatment ends.

I understand that Jennifer Reid, LSCSW may (unless court ordered) hesitate to release information if Ms. Reid states in writing that releasing the information would be harmful to the patient.

I understand that I have the right to inspect the information being disclosed.

I, the undersigned, have read the above and authorized the request or disclosure of Protected Health Information as described. I understand that treatment is not conditioned upon the execution of this authorization. I understand that Jennifer Reid, LSCSW cannot assure that the recipient will maintain confidentiality of this information being authorized to be released. I understand that Jennifer Reid, LSCSW may charge a fee to provide copies of records and will apply guidelines and fee schedules established for compliance with the Kansas Open Records Act for this purpose.

If record includes information about substance abuse, patient must sign, including minors.

When sending information, send to the attention of:

Jennifer Reid, LSCSW
643 N. Armour St.
Wichita, Kansas 67206

____
Patient Printed Name

____
Patient Signature (16 and over)

____
Signature of Parent or Guardian of Patient

____
Parent or Guardian of Patient Address

____

____
Patient Address

____
City State Zip

____
Patient Social Security Number Date of Birth

____
Date

____

City	State	Zip	Witness