PHYSICIAN RELEASE/WAIVER

By Kansas statute I am required to consult with your primary care physician or psychiatrist to determine if there is a medical condition or medication which may be contributing to your symptoms. You are required to provide me with the name and mailing address of your physician, or sign a waiver stating you do not wish for me to contact your physician.

Please contact my physician: Dr. _____

address_____

_____ _____

Client signature date

I **waive** my right for you to **contact** my physician. I do not wish for you to consult my physician.

_____ _____

Client Signature date

I **authorize** payment of **insurance benefits** to *Katherine Smith, MS, LCMFT* for counseling services.

_____ _____

Client signature date