Authorization for Release of Information

Provider: Emily J. Runyan, LCP
Emily J. Runyan LCP, LLC
4601 East Douglas Ave, Ste 128
Wichita, KS 67218

Client(s) Information

Name:_____ Date of Birth _____ / _____ / _____

Address:_____
Street City State Zip

Contact Information:_____
Phone Fax Email

Receiving Party

Name:_____ Relationship to Client(s):_____

Address:_____
Street City State Zip

Contact Information:_____
Phone Fax Email

Information to Be Released

_____Whether the client is in treatment or not
_____Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case)
_____Nature of the services offered
_____Brief statement regarding prognosis
_____Other_____

Purpose of the Release

_____Referral to other services
_____Coordination of care
_____Consultation with doctor
_____Consultation with other mental health provider
_____Transfer of care
_____Other_____

Signature of Client and Therapist

This information lasts for one year after the date you sign it unless you enter a different date or expiration here:_____. This authorization may be cancelled in writing at any time. Your signature indicates that you have read and understand this form and authorizes release of your information as described above. You understand that you may refuse to sign this authorization and that refusal to sign will not affect treatment.

_____ _____ _____ _____
Client Signature Date Therapist Signature Date