Willow Tree, LLC
7348 W 21st St N #107
Wichita, KS 67205
Phone: (316) 779-2560 Fax: (316) 854-2303

Authorization & Request of Confidential and Privileged Information

In accordance with my legal right to confidentiality and privileged communication relevant to the services that I have received, I authorize and request the disclosure of confidential information ***from*** Willow Tree, LLC ***to*** the following individual or agency. Additionally, I authorize and request release of confidential information ***from*** the following individual or agency ***to*** Willow Tree, LLC

You may fax information back to: (316) 854-2303 (please call (316) 779-2560 if problems or questions).

Agency or Individual Name:			
Street:	City:	State:	Zip:
Phone:	Fax:		

Client [or Guardian] authorizing release:

Name:			
Street:	City:	State:	Zip:
Phone:	Date of Birth:		

By signing below, the client is releasing and authorizing:

- a summary report of services received by ***both*** the indicated clinician as well as the agency or individual noted above.
- consultation and/or verbal communication between the above names parties.
- any and all records pertaining to services received by both the indicated clinician as well as the agency or individual noted above.

It is my understanding this information will be used for consultation and treatment purposes.

This consent expires one year from the date noted below unless revoked by me in writing at an earlier time.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

In accordance with federal regulations (42 CFR Part 2) which prohibits any further disclosure of this information, except with specific written consent of the person to whom it pertains, re-disclosure of this information is prohibited.

I hereby hold harmless the above-named practitioner from any liability relevant to the release of the confidential information or privileged communication. I agree to pay a reasonable fee, if any, for the preparation of the information released.

Printed Name of Client:	
Client [or Guardian] Signature:	Date (expires in one year): / /
Clinician Signature:	Date: