Dr. Sarah L. Wesch, Ph.D. LLC
104 S. 4th St. Suite 6
Manhattan, KS 66502

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

Note: None of the information or records obtained under this authorization may be re-released to another party.

Client Name Date of Birth

Name/contact information of person or agency from whom you are authorizing the release of information:

Check here if you consent to having your records faxed: ☐

I, _________________________, hereby authorize the exchange of my personal information between Dr. Sarah L. Wesch, Ph.D. and the above person/agency. That information may include:

☐ Confirmation of participation in therapy

☐ Psychological testing results

☐ Treatment summary

☐ Medical records (medications, dosage, diagnoses)

☐ Other:

This information is to be released for purpose of:

☐ Treatment planning

☐ Coordination of Care

☐ Other:

This authorization shall remain in effect until:

☐ Specific date:

☐ Until revoked.

☐ Other:

Signature of Patient/Date

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address.