Ginger E. Brown, LSCSW, RPT
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WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION

I understand that under the provisions of KSA 65-6404 (b) (3) my therapist is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that is causing or contributing to any observed symptoms of a mental disorder in either myself or my minor child(ren) listed below:

Name of Minor child	*Name of Minor child*
Name of Minor child	*Name of Minor child*
Name of Minor child	*Name of Minor child*
Name of Minor child	*Name of Minor child*

In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my therapist has recommended that I seek medical consultation.

By signing below I am indicating that I waive my right to such consultation and that I do not wish for my therapist to contact my(our) physician(s). I am also aware that this waiver will become part of my client record.

Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date