WESTSIDE CHRISTIAN COUNSELING CENTER

WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION

I understand that under the provisions of KSA 65-6404 (b) (3) my therapist(s) is/are required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that she or he may have observed while working with me 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(s) has/have recommended that I seek medical consultation.

By signing below I am indicating that I waive my right to such consultation and that I am 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
Therapist Signature	Date	Therapist Signature	Date
Therapist Signature	Date	Therapist Signature	Date
Therapist Signature	Date	Therapist Signature	Date