Diane K. Schmidt Counseling Services
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State of Kansas Physician Consult

I understand that when I describe symptoms that may be consistent with a mental disorder, these symptoms can have medical or biological origins and that my therapist must consult with my physician, unless I waive this requirement.

☐ No, I do not want my therapist to contact my physician and I waive this requirement. (Please sign below.)

_____ _____
Client Signature Date

☐ Yes, I request that my therapist consult with my physician regarding my mental health. (Please sign below.)

_____ _____
Client Signature Date

Physician's Name: _____

Address: _____

Phone: _____