

EXCHANGE OF INFORMATION FORM

Client \_\_\_\_\_ DOB \_\_\_\_\_

Because your mental and physical health are closely related I am required to communicate with your physician unless you waive this right.

I do \_\_\_ do not \_\_\_ wish for my physician to be contacted regarding my care.

\_\_\_\_\_ Date \_\_\_\_\_  
Client or Parent/Guardian

Behavioral Health Provider Info:  
Cynthia A. Schendel, LSCSW Office: 913 451 1900  
8575 W. 110<sup>th</sup> Ste. 304 Fax: 913 345 9335  
Overland Park, KS 66210

Medical practitioner(s) with whom you would like me to communicate:

Name \_\_\_\_\_ Phone/fax: \_\_\_\_\_  
Address \_\_\_\_\_

Name \_\_\_\_\_ Phone/fax: \_\_\_\_\_  
Address \_\_\_\_\_

I, the undersigned, voluntarily authorize Cynthia A. Schendel to communicate with the medical practitioner(s) listed above in order to facilitate continuity and coordination of my care. I understand this may include information regarding substance abuse, STD's or pregnancy. This consent may be revoked at any time except to the extent that action has already been taken. In any event it shall expire one year from the date of signature.

\_\_\_\_\_ Date \_\_\_\_\_  
Client or Parent/Guardian

Dear Dr. \_\_\_\_\_:

The patient named above is being treated for the following behavioral/mental health problems:

Current stressors: \_\_\_\_\_

Patient reports taking the following medications: \_\_\_\_\_

I recommend the patient be evaluated for medication to treat \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_  
Cynthia A. Schendel, LSCSW

Date form mailed or faxed to medical practitioner: \_\_\_\_\_