AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

FOR PRIMARY CARE PHYSICIAN

I, _____ for _____ DOB: _____
(Parent/Guardian Name if Client is a Minor) (Client Name) (Client's Date of Birth)

authorize **I. Randy Kulman, Ph.D**. to: Release to _____ Request from _____

Name: _____ Agency: _____

Address: _____

the following information:

__ Academic Testing Results
__ Behavior Programs
__ Medical Reports
__ Progress Reports
__ Other (Specify): _____
__ Psychological Testing Results
__ Cognitive Testing Results
__ Personality Profiles
__ Report Cards/IEPs/504 Plans
__ Service/Treatment Plans
__ Case/Progress Notes
__ Treatment Summaries
__ Psychiatric Evaluations

The above information will be used for the following purposes:

__ Planning appropriate treatment or program
__ Determining eligibility for benefits or program
__ Updating files
__ Continuing appropriate treatment or program
__ Case review
__ Other (Specify): _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed as to what information will be shared, its purpose, and who will receive the information. I expressly agree to this exchange as long as the information described herein is disseminated as described above, and indemnify and hold harmless I. Randy Kulman, Ph.D. and South County Child and Family Consultants, Inc., from any resulting actions, harm, injury, and the like. I understand that my or my child's records are protected under RI General Law and cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that if my or my child's records involve alcohol or substance abuse that they are protected under Federal Regulations 42CFR, Confidentiality of Drug and Alcohol Abuse. I have read or have been read to and understand the above statements and voluntarily consent to disclosure of the above information and/or mental health records (including HIV (AIDS) related records) to those persons/agencies named above. By signing this release, I am allowing disclosure of such information.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If Client is a Minor)

Witness Signature: _____ Date: _____

1058 Kingstown Road, Peace Dale, RI 02879
Phone: 401/789-1553 Fax: 401/782-1313