AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____
Printed Name of Patient Previous Names, if applicable

_____ _____
Date of Birth Daytime Telephone Number

I authorize any individual from the below named institution to release information to:

SEND INFORMATION TO: (please be specific)

Provider Name/Organization: Joseph F. Kulas, Ph.D., ABPP

Address: 270 Farmington Avenue, Suite #344

Farmington, CT 06032

Phone #: (203) 805 - 8527 Fax # (203) 271 - 2320

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization: _____

Address: _____

Phone #: _____ Fax # _____

PURPOSE OF DISCLOSURE: [] Transfer of Care [] Self [] Specialist

[] Other (must complete) _____

INFORMATION TO BE DISCLOSED:

[] IP Medical Records Date(s) of Service: _____
[] Summary Health Information [] Complete Designated Record Set

[] Other _____ Expiration Date (or event) _____

If the patient (guardian) is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 60 days of receipt, and may be revoked at any time, except to the extent that action has been taken in reliance thereon. To revoke this authorization, send or present your written revocation to Dr. Kulas. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to redisclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996.

_____ _____ _____
Date Signature of patient/representative Relationship to patient

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of information relating to the testing, diagnosis, or treatment for HIV Related information, Mental Health/Psychiatric Disorders and/or Drug and Alcohol Abuse Records

_____ _____ _____
Date Signature of patient/representative Relationship to patient