Jeffrey Ulmer, Ph.D. **Clinical Psychology**

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Authorization and Release for the Exchange of Confidential and Privileged Information: Clinical and Forensic

I hereby authorize Jeffrey Michael Ulmer, Ph.D. to release or exchange the following information:

1. Psychological Summary
2. Psychological Evaluation/Test Results
3. Treatment or Discharge Summary
4. School Records
5. Medical Records*
6. Other_____

Client Name: _____

To or with the following individuals or organizations:
(Circle number corresponding to information sought)

1 2 3 4 5 6

_____
Individual/Organization

_____
Street or P.O. Box

_____
City Zip

_____
Phone

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1 2 3 4 5 6

_____
Individual/Organization

_____
Street or P.O. Box

_____
City Zip

_____
Phone

*I Understand that this consent, unless specifically limited by me in writing below, will extend to all aspects of treatment. This includes the diagnosis and treatment of AIDS or other sexually transmitted diseases, drug and/or alcohol abuse or psychiatric treatment.

Limits/Exclusions: _____

Unless otherwise specified in writing this consent expires 90 days after psychological services by Dr. Ulmer to the client are terminated. I understand that I have no obligation to disclose the requested information and that I may revoke this consent at any time, except insofar as action has been taken in reliance on upon it, by informing Dr. Ulmer in writing. I hereby release Dr. Ulmer and his staff from all legal responsibility or liability that may arise from release of this information and these records. No further disclosure of this information is permitted unless expressly permitted by the written consent of the person to whom it pertains. A Photostat copy shall be considered as effective and valid as the original. By my signature below I affirm that this consent is voluntarily and freely given.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Witness Date