Ronitte Vilker , Ph.D.
3657 Post Rd. Suite 6
Warwick, RI 02886
(401) 921-3220

PLEASE FORWARD ALL INFORMATION TO OR BRING TO APPOINTMENT:

Ronitte Vilker, Ph.D. 3657 Post Rd Suite 6, Warwick, RI 02886; Confidential Fax (401) 921-2263

RELEASE OF INFORMATION FORM

Client Name: ________________________________ **DOB:** ________________________
Address/Street: ________________________________ **Apartment #:** ______________
City / Town: ________________________________ **State:** _____ **Zip Code:** _______

I, ________________________________ authorize Ronitte Vilker, Ph.D. to obtain confidential
(Client Name)
information **from and/or provide** confidential information to the following:

Check One: **Name and Address:**

__ Physician/Medical ____
__ Mental Health Professional ____
__ School Department ____
__ Other ____

Check Confidential Information to be Released or Obtained:

__ Referral and/or Admission Information
__ Assessments/Treatment Plans
__ Summary Reports
__ Educational / IEP Information
__ Social / Family History
__ Medical History
__ Evaluations
__ Telephone Communication
__ Other (specify) ________________________________
__ Transcripts
__ Information pertaining to me, my prognosis, diagnosis or treatment
__ Any and all Agency Records

Dates of Service: __________ Method of Release: ___ Telephone / Verbal ___ Photocopies ___ Fax ___ Email

The purpose of this information is for: ____________________________

I have read carefully the above statements and do voluntarily consent to disclosure of the above information (including alcohol, and drug treatment, and HIV (AIDS) related records) and/or Medical, School Records to those persons or agency named above. I understand that my records are protected under the Federal Confidentiality regulations (42CRF part 2) published July 1, 1975, and/or the General Laws of the State of Rhode Island, cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that if I authorize Ronitte Vilker, Ph.D. to disclose information, the recipient of the information might disclose it to others, and that information disclosed by Ronitte Vilker, Ph.D. may no longer be protected by the federal rule on the privacy of medical records. I also understand that I may withdraw or revoke this consent (in written revocation) at any time except to the extent action has been taken in reliance on it (e.g. probation, parole, etc.) and that in the event this consent expires automatically as described below:

This consent expires in one year from date signed

Client Signature:: ____ **Date**: ______________

Witness Signature: ____ **Date**: ______________