JUDITH E. PENTZ, M.D.
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Phone 505 883-9580 Fax 505 883-9587

AUTHORIZATION TO DISCLOSE AND/OR OBTAIN PROTECTED HEALTH INFORMATION

I, _____, DOB: _____ hereby authorize
(Patient's Name) (Patient's DOB)
Judith E. Pentz, M.D. to (check the one that applies):

☐ Obtain information from ☐ Exchange verbal communication with

Name or Organization:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

In the spaces below mark the ones that you specifically authorize the release or discloser of the following protected health information:

_____ Discharge Summary	_____Psychological Testing	_____Billing Information
_____Neuropsychological Testing	_____Treatment Plan	_____Laboratory Reports
_____Outpatient Assessment	_____History and Physical	_____Psychiatric Evaluation/Assessment

Service Dates to disclose records:_____

All consents to release medical records and/or communicate will expire in 1 year from date signed unless otherwise stated by patient. I wish to have content to expire on _____.

Any exclusion to the above consent:
_____
_____
_____

My medical records may include information regarding diagnosis and treatment of drug, alcohol, AIDS, HIV Serology, or Psychiatric Disorders. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulations (42 CFR part 2) prohibits them making any further disclosure without your written consent or as otherwise permitted by such regulations. I also understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to the office of Dr. Judith E. Pentz.

_____
Patient/Parent Signature (if patient is a minor) or Legal Representative

_____
Date