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**CONSENT TO RECEIVE AND OR RELEASE CONFIDENTIAL INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize **Eric Greenman, M. D.**, 10165 N. 92<sup>ND</sup> ST., STE 101, Scottsdale, Arizona 85258 to

\_\_\_\_\_ receive from: \_\_\_\_\_ release to: \_\_\_\_\_ exchange information with:

\_\_\_\_\_  
Name/Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

[ ] \_\_\_\_\_ [ ] \_\_\_\_\_  
Telephone Number Fax

the information below with regard to the services provided to me for the period of treatment from \_\_\_\_\_ to \_\_\_\_\_.

Purpose of Disclosure:

Information to be furnished:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> History & Physical      | <input type="checkbox"/> Treatment & Discharge | <input type="checkbox"/> Speech & Hearing     |
| <input type="checkbox"/> Psychological Testing   | Summary  | Evaluation                                    |
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Lab Results           | <input type="checkbox"/> Consultations        |
| <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> EEG, MRI, CT Reports  | <input type="checkbox"/> Adjunctive Therapist |
| <input type="checkbox"/> Stress Audit            |  | Evals (OT, PT, etc.)                          |
| <input type="checkbox"/> Other                   |  |   |

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This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization is subject to revocation by me at any time except to the extent action has been taken in reliance herein. If not earlier revoked, it shall terminate automatically 12 months after the date of my signature.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian/Conservator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date