synergyhealth | RECORDS REQUEST

RECORDS REQUEST

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

The above listed patient authorizes the following healthcare facility to make healthcare disclosure

Facility Name: _____ Facility Phone: _____

Facility Address: _____

City: _____ State: _____ Zip Code: _____

Dates and type of information to disclose:

- 2 Years Prior from Last Date Seen
- Dates Other: _____
- Specific Information Requested:_____
  _____

Reason for Disclosure:

- Change of Insurance or Physician
- Continuation/Continuity of Care
- Referral Other:_____
  _____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immuno deficiency syndrome (AIDS), or human immuno deficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This information may be disclosed and used by the following individual or organization: **Release To: Synergy Integrated Healthcare Address (Please Fax Records): 13020 Livingston Road, Suite 14, Naples, FL 34105, Fax: 239-263-7492, Phone: 239-263-3330**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or unauthorized red is closure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar and fully understand the terms and conditions of this authorization.

Signature of Patient/Parent/Guardian
or Authorized Representative: _____ Date:_____

Name of Authorized Representative: _____ Date:_____