SYNERGY
Primary Care

MEDICAL RECORD RELEASE AUTHORIZATION FROM SYNERGY PRIMARY CARE

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of *minors*, *HIV*, *psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: SYNERGY PRIMARY CARE to release information on
(Physician/ Healthcare Facility)

_____ , _____ regarding my medical
(Patient's Name) (Patient's DOB)

history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:

_____
Practice Name

_____
Street Address

_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose:

_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information: _____

_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)

Psychiatric/Mental Health _____(initial)

Tests for Antibodies to HIV _____(initial)

HIV Diagnosis/Treatment _____(initial)

Genetic Information _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____.
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____	_____
Signature of Patient/ Legal Personal Representative	Relationship (if other than self)
_____	_____
Patient's Name (PRINT)	Date
_____	_____
Patient's Social Security Number	Patient's Date of Birth
_____	_____
Witness Name	Witness Signature