



Synergique Healing, PA

Behavioral Health & Functional Medicine

Authorization To Disclose Medical Information

Patient's Name _____ Date of Birth _____

Address: _____ Apt#/Unit _____

City: _____, State: _____ Zip: _____ Phone# _____

Disclose Medical Information to:

Entity: _____

Address: _____ Suite/Unit #: _____

City: _____, State: _____ Zip: _____

Phone _____ Fax _____

Purpose: I authorize the release of my health information for the following specific purpose:

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- | | |
|--|--|
| ☐ All Records | ☐ Progress Notes |
| ☐ Only Dates From: _____ to _____ | ☐ Psychological Report |
| ☐ Initial Psychiatric Evaluation | ☐ Laboratory Reports/ Results |
| ☐ Medication Information | ☐ Other: _____ |

I grant special authorization for the following information (**Please Initial**) to be shared:

_____ Psychotherapy Notes _____ Alcohol/Drug Abuse

I acknowledge and understand this authorization will waive my rights to confidentiality regarding the information released per this consent. I hereby release Synergique Healing, PA, and its staff from all liability that could arise from the release and disclosure of the information or records. This agreement shall remain in effect for a limit of one year from the date signed unless otherwise stated. Additionally, a photocopy or fax of this authorization is as valid as the original.

This authorization can be canceled upon the patient's written request,; however, any disclosures already made before receiving the patient's request will not receive any effects. In addition, we have no control over how the agency/ person authorized to receive this information under this consent chooses to utilize it.

Signature: _____ **Date:** _____

Name and relationship to Patients (If differ.): _____

***If signed electronically, Date of Birth of signer:** _____ **Phone#:** _____

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